SERFF Tracking Number:	*AMAL-126949636*	*State:*	*Arkansas*
Filing Company:	*Amalgamated Life Insurance Company*	*State Tracking Number:*	*48202*
Company Tracking Number:	*ALSTDP-AR-05*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Short Term Disability Income*		
Project Name/Number:	*Group Short Term Disability /ALSTDP-AR-05*		

Filing at a Glance

Company: Amalgamated Life Insurance Company

Product Name: Group Short Term Disability Income	SERFF Tr Num: AMAL-126949636	State: Arkansas
TOI: H11G Group Health - Disability Income	SERFF Status: Closed-Approved-Closed	State Tr Num: 48202
Sub-TOI: H11G.002 Short Term	Co Tr Num: ALSTDP-AR-05	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Jayne Monaco	Disposition Date: 03/09/2011
	Date Submitted: 03/09/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

General Information

Project Name: Group Short Term Disability	Status of Filing in Domicile: Authorized
Project Number: ALSTDP-AR-05	Date Approved in Domicile: 04/06/2010
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer, Association, Other	Explanation for Other Group Market Type: Labor Union
Overall Rate Impact:	Filing Status Changed: 03/09/2011
	State Status Changed: 03/09/2011
Deemer Date:	Created By: Jayne Monaco
Submitted By: Jayne Monaco	Corresponding Filing Tracking Number: ALSTDP-AR-05

Filing Description:
Re: AMALGAMATED LIFE INSURANCE COMPANY NAIC # 60216
Form ALSTDP-AR -05 – Group Short Term Disability Policy
Form ALSTDC-AR -05 – Group Short Term Disability Certificate

Enclosed for your review and approval are the above-named forms. These forms are new and will not replace any other previously filed or approved forms.

SERFF Tracking Number:	*AMAL-126949636*	*State:*	*Arkansas*
Filing Company:	*Amalgamated Life Insurance Company*	*State Tracking Number:*	*48202*
Company Tracking Number:	*ALSTDP-AR-05*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Short Term Disability Income*		
Project Name/Number:	*Group Short Term Disability /ALSTDP-AR-05*		

Form ALSTDP-AR-05, Group Short Term Disability Income Insurance Policy provides voluntary disability income protection to an individual insured upon disability resulting from bodily injury, sickness or pregnancy. Form ALSTDC-AR-05, Individual Certificate – Group Short Term Disability Insurance, is provided to the individual insured as evidence of coverage under the group policy. Bracketed text within the policy forms indicates variability dependent primarily upon the type of group to which the policy is issued and the insured benefits selected. Attached is the "Statement of Variable Language, Form MOVL-ALSTD-10(AR).

Intended Market
This policy is intended to be marketed primarily to labor union groups but may also be marketed to employer groups and employee welfare trust funds. The product will be sold through Amalgamated Life Sales Executives and brokerage firms. Amalgamated Life specializes in the labor union market serving the needs of the members of labor unions and employee welfare trust funds.

Applications
Forms ALLIDIEOI-AR-10, Evidence of Insurability ALLIDIE-AR-10, Life/Disability Enrollment Form and ALLIDIA-AR-10, Group Policy Application, which were previously approved by your Department (9/19/2010, SERFF# AMAL126774572), will also be used to apply for coverage under this policy.

Also attached is an Actuarial Memorandum, Rating Manual, and any other certifications required by your state.

The forms have been completed in John Doe fashion and are subject to minor modification in paper size and stock, ink, logo, border and adaptation to electronic printing.

Please call me if you have any questions or need additional information

Company and Contact

Filing Contact Information

Jayne Monaco, Consultant
333 Westchester Ave
White Plains, NY 10604
jmonaco@amalgamatedlife.com
914-367-5591 [Phone]
914-367-5786 [FAX]

Filing Company Information

Amalgamated Life Insurance Company	CoCode: 60216	State of Domicile: New York
333 Westchester Ave.	Group Code:	Company Type:
White Plains, NY 10604	Group Name:	State ID Number:
(914) 367-5581 ext. [Phone]	FEIN Number: 13-5501223	

SERFF Tracking Number:	*AMAL-126949636*	*State:*	*Arkansas*
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Project Name/Number:	*Group Short Term Disability /ALSTDP-AR-05*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	Filing and review of life and health policy and certificate = $50.00 per form.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Amalgamated Life Insurance Company	$100.00	03/09/2011	45414936

SERFF Tracking Number:	*AMAL-126949636*	*State:*	*Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/09/2011	03/09/2011

SERFF Tracking Number:	*AMAL-126949636*	*State:*	*Arkansas*
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Disposition

Disposition Date: 03/09/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMAL-126949636*	*State:*	*Arkansas*
Filing Company:	*Amalgamated Life Insurance Company*	*State Tracking Number:*	*48202*
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Statement of Variable Language	Approved-Closed	Yes
Supporting Document	Previously approved applications	Approved-Closed	Yes
Supporting Document	Actuarial Memorandum and Rating Manual	Approved-Closed	No
Form	Group Short Term Disability Income Policy	Approved-Closed	Yes
Form	Individual Certificate - Group Short Term Disability Income Insurance	Approved-Closed	Yes

SERFF Tracking Number:	*AMAL-126949636*	*State:*	*Arkansas*
Filing Company:	*Amalgamated Life Insurance Company*	*State Tracking Number:*	*48202*
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Form Schedule

Lead Form Number: ALSTDP-AR-05

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/09/2011	ALSTDP-AR-05	Policy/Contract/Fraternal Certificate	Group Short Term Disability Income Policy	Initial		49.900	ALSTDP-AR-05 - Group Short Term Disability Income Insurance Policy.pdf
Approved-Closed 03/09/2011	ALSTDC-AR-05	Certificate	Individual Certificate - Group Short Term Disability Income Insurance	Initial		47.700	ALSTDC-AR-05 - Group Short Term Disability Income Insurance Certificate.pdf

AMALGAMATED LIFE INSURANCE COMPANY
Home Office: [333 Westchester Ave., White Plains, NY 10604]

GROUP SHORT TERM DISABILITY INCOME INSURANCE GROUP POLICY

Group Policyholder's Name	**[A-Z Services, Inc]**
[The Participant Employer:	**[John Doe & Associates]]**
Group Policy Number	**[GLT-123456]**
[The Participant Employer Number	**[PEN-100001]]**
Group Policyholder's Address	**[123 Main Street, Big City, AR]**
Effective Date of Group Policy	**[MM/DD/YY]**
Place of Delivery	**[Big City], AR**
Anniversary Dates	**[October] [1], of each year beginning [2010]**
Premium Due Date	**[Monthly], [on the first day of each policy month]**

CONSIDERATION AND INSURING CLAUSE

In consideration of the representations in the Policy application (copy attached and made part hereof); and upon payment of the premiums as provided and subject to all the exceptions, limitations, reductions and other terms of the Policy; the Company (Amalgamated Life Insurance Company) hereby agrees with the Policyholder:

TO PROVIDE Short Term Disability Income Insurance to "Eligible Persons" who are enrolled according to the terms of this Policy.

The first premium is due and payable on the effective date of the policy. Subject to the policy's grace period provision, all premiums after the first must be paid when or before they are due.

This Policy is issued for delivery in Arkansas.

David J. Walsh
President

Group Short Term Disability Income Insurance Policy
Non-Participating

TABLE OF CONTENTS

Table of Contents of Certificate of Insurance ALSTDC-AR-05 (Incorporated Into this Policy Form).

POLICYHOLDER

A Policyholder means [a labor union/ a health & welfare trust fund/ or simply an employer] to which the Group Policy is issued.

An employer may be included as a Participant Employer if the Policyholder and the Company so agree. The Company will keep a list of accepted Participant Employers; and the effective dates of coverage for each.

The Policyholder may act for or on behalf of all Participant Employers in all matters of the policy. The following will be binding on all Participant Employers:

- all agreements between the Company and the Policyholder;
- all notices from the Company to the Policyholder; and
- all notices from the Policyholder to the Company.

An employee of a Participant Employer will be deemed to be an employee of the Policyholder for insurance purposes.

Coverage for a Participant Employer will terminate on the first to occur of:

- the date his premium is due, but not paid; or
- the date on which the Policyholder wants the employer to be removed from the policy. Such date must be stated in written notice to the Company; and it must be after the date of the notice.

INCORPORATION PROVISION

Incorporation of the Certificate of Insurance

The Certificate of Insurance is attached to this Policy; and it is hereby incorporated in and made part of this policy.

The terms found in the Certificate of Insurance will control:

- the benefit plan provisions;
- the eligibility and effective date of insurance rules;
- the termination of insurance rules;
- exclusions; and
- other general policy provisions pertaining to state insurance law requirements.

The following table sets forth the list of current Certificate along with Endorsement & Rider Forms attached to the Certificate – all of which are made part of the Group Policy.

Form	Form Number	Effective Date
Group Short Term Insurance Certificate	ALSTDC-AR-05	mm/dd/yy

The following table sets forth the list of Endorsements and Rider Forms attached to this Group Policy and made part of the Group Policy.

Form	Form Number	Effective Date

SCHEDULE OF INSURANCE

Schedule of Insurance
The Schedule of Insurance is as shown in the Certificate of Insurance.

The Schedule of Insurance will control the:
- benefit amounts and maximum limits;
- eligibility and effective date rules; and
- other schedule amounts and limits,

which apply to the employees of the Policyholder.

PREMIUMS

Initial Monthly Premium Rates
The initial monthly premium rates to be charged for employee Coverage will be:

Short Term Disability Income Insurance [$XXX.XX per [$100] of Insured Payroll/ [$ Insured_Payroll_Text]].

[For Short Term Disability Benefits, the amount of an employee's Earnings may be disregarded in determining his Monthly Benefit because of the Maximum Monthly Benefit limit; in such a case his Monthly Benefit will also be disregarded in determining the amount of the total insured payroll.]

The Initial Monthly Premium Rates may be converted as follows:

To Convert Rates to:	Use a Conversion Factor of:
annual rates:	11.8227
semi-annual rates:	5.9557
quarterly rates:	2.9852

Change in Monthly Premium Rates
Initial Monthly Premium rates are guaranteed for [12] months.

Subject to the Rate Guarantee period shown above, the Company has the right to change premium rates on any premium due date if:
- written notice is delivered to the Policyholder's last address on record; and
- the change is effective at least [31/45] days after the date of notice.

The rate guarantee described above (the “Rate Guarantee”) supersedes only those provisions

appearing elsewhere in this policy which give the Company the right to change the premium rates, and then, only for the period of time stated for the Rate Guarantee. However, the Company may change the premium rates during the Rate Guarantee period:

- if there is a change in the policy; and or if there is a [10%] increase or decrease in the number of insured employees; or
- if the Policyholder adds or deletes a subsidiary and or an affiliated business entity.

The Company may also change the premium rates during the guarantee period if there has been a material misstatement in the reported experience during the pre-sale process. The Rate Guarantee in no way affects, amends or supersedes any other provision in this policy.

Calculation
Premiums may be calculated by multiplying the rate times the applicable number of units of coverage.

If any insurance is added, increased or becomes effective after the policy is in force, the premium charges will begin:

- the day the coverage is effective, if it is also the first day of a policy month; or if not
- the first day of the next policy month.

For insurance which is terminated, premium charges will stop as of the first day of the next policy month.

Premiums may be calculated by any other method which both the Company and the Policyholder agree to in writing.

Premium Payments
Premium payments are due and payable in full to a place designated by the Company or, with respect to the initial premium payment, premium payments may be made to an authorized agent of the Company.

Payment of premiums for a period before it is due will not guarantee the insurance for that period.

[Experience Rating Refund
If the policy is experience rated, any credit amount due the Policyholder will be allowed him at the end of every [2] Policy Years and, at the Policyholder's request, will be:

- paid to him in cash;
- used to reduce his premiums; or
- used to provide additional insurance for Covered Persons.

Any credit amount shall be determined by the rating plan or plans used by the Company.]

POLICY PROVISIONS

Entire Contract
The contract between the Company and the Policyholder consists of:

- the Policy;
- the Certificate of Insurance incorporated into the Policy;
- the Application of the Policyholder, a copy of which is attached to and made a part of the policy when issued; and
- the Enrollment form and the Eligibility of Insurance form, if any, of each insured person (copy attached).

All statements made by the Policyholder, Participant Employers, and persons insured under the policy are true and complete to the best of the knowledge and belief of the person(s) making them. No statement will be used in any contest unless it is in writing and a copy of it is given to the person who made it, or to his beneficiary.

Right to Examine Policy
The Policy may be returned within 31 days after receipt if the Policyholder is not satisfied for any reasons; any premium paid will then be refunded.

Incontestability
Except for non-payment of premium, the insurance provided by the policy cannot be contested after a period of 2 years from the date of issue of such insurance.

Change in The Policy
The Company may not make any change unless approved in writing by the President; or a Vice President; or an Assistant Vice President; of the Company. No other person may change or waive any part of the policy. Any approved change shall be added to the policy in writing.

If any change to state or federal law, including but not limited to the Federal Social Security Act, affects the Company's liability under the policy, the Company may change the policy, the premiums or both. Such change:

- will be effective as of the date of the change to the state or federal law;
- will not be made until the Company gives the Policyholder 31 days notice.

Right to Amend
Notwithstanding the above, after the policy has been in force for 12 months, the Company may change any or all of the provisions of this contract by notifying the Policyholder. The Company must give the Policyholder at least 31 days advance written notice of any change.

Grace Period
The Company will allow the Policyholder a 31-day grace period for the payment of all premiums after the first. During this 31-day period, the policy will stay in force. If the owed premium is not paid by the 31st day, the policy will automatically terminate. If the Policyholder gives the Company written advance notice of an earlier cancellation date, the policy will terminate on the earlier date. Premium is due for each day the policy is in force.

Termination of Policy
The Company may terminate the policy for the following reasons by giving the Policyholder [31-60] days written notice:

- The Policyholder fails to furnish any information which the Company may reasonably require;
- The Policyholder fails to perform any of his other obligations pertaining to this policy;
- Less than 100% of the persons eligible for coverage on a Non-contributory Basis are insured; or
- Less than [75%] of the persons eligible for coverage on a Contributory Basis are insured.
- Fewer than 10 persons are insured.

[In addition, the Company may terminate this policy on any premium due date after the policy has been in force for 12 months.]

Certificate
The Company will give the Policyholder [or Participant Employer] an individual Certificate of Insurance for each insured employee. The certificate is part of the policy, and will explain the important features of the policy.

Data To Be Furnished
The Policyholder will give the Company all required information regarding matters pertaining to the insurance. At any reasonable time while the policy is in force and for 1 year after that, the Company may inspect any of the following:

- Policyholder's documents;
- its books; or
- its records;

which may affect the insurance or premiums of this policy.

If the Policyholder gives the Company any incorrect information, the relevant facts will be determined to establish:

- if insurance is in effect ; and,
- if it is, then for what amount.

The Company will not deprive any one of insurance to which he is otherwise entitled or have insurance to which he is not entitled, because of any misstatement of fact by the Policyholder. Any required adjustment may be made in premiums or benefits.

No Replacement for Workers' Compensation
The policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

Time Period
All periods begin and end at 12:01 A.M., standard time, at the Policyholder's address.

Jurisdiction
The laws of the state of Arkansas govern this Policy.

AMALGAMATED LIFE INSURANCE COMPANY
Home Office: [333 Westchester Ave., White Plains, NY 10604]

GROUP SHORT TERM DISABILITY INCOME INSURANCE
CERTIFICATE OF INSURANCE

Effective Date of Certificate	**[MM/DD/YY]**
Certificate Holder's Name	**[Jane Jones]**
Group Policyholder's Name	**[A-Z Services, Inc]**
[The Participant Employer Name:	**[John Doe & Associates]]**
Group Policy Number	**[GLT-123456]**
Group Policyholder's Address	**[123 Main Street, Big City, AR]**
[Participant Employer Number	**[PEN-100001]]**
Effective Date of Group Policy	**[MM/DD/YY]**

Insurer Information Notice

Any questions regarding the plan may be directed to us at our Home office at:
333 Westchester Ave., White Plains, NY 10604

If the question is not resolved, you may contact the Arkansas Insurance Department:
Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
Telephone: 1-800-852-5494
This notice is for information only and does not become a condition of the plan.

This is to certify that, subject to the terms of the Group Policy under which this Certificate is issued, You are insured for the benefits as shown in the Schedule of Insurance and described in this Certificate.

Insurance takes effect only if You are eligible for it, You elect it and You make contribution for it as required.

This certificate takes the place of any prior one issued to You by Us covering the insurance. It is not an insurance contract. The group insurance contract is held by the Group Policyholder. You may request to inspect it at the Policyholder's office during usual business hours.

Amalgamated Life Insurance Company certifies that it has issued Group Policy [GLT-123456] and that the person named in this Certificate, and whose premium is paid, is insured for the benefits described, subject to the terms and conditions of the Group Policy. This Certificate provides valuable information about Your benefit plan under the Group Policy. **Read Your Certificate Carefully**

David J. Walsh
President

Individual Certificate – Group Short Term Disability Insurance

TABLE OF CONTENTS

SCHEDULE OF INSURANCE

The Group Insurance Policy: [GLT-123456]

The Plan Effective Date: [MM/DD/YY]

The Policyholder: [A-Z Services, Inc.]

[The Participant Employer: [John Doe & Associates]]

You **[**must/do not**]** contribute towards the plan's cost.

This plan of Short Term Disability Insurance provides you with short-term income protection if you become Disabled from a covered accident, sickness or pregnancy.

ELIGIBILITY

Eligible Classes:	**[**All Active Full-Time **[**Employees**]** who are U.S. citizens or U.S. residents, excluding temporary and seasonal [Employees**]]**
Full-Time Employment:	**[**20-40**]** hours weekly

Eligibility Waiting Period is the length of continuous service during which you must be an Active Full-time [Employee] in a class eligible for insurance before you become eligible for coverage. It is as follows:

(1) If you are working for the Employer on the Policy Effective Date - **[**none - 365 days/12 months**]**
(2) If you start working for the Employer after the Policy Effective Date - **[**none - 365 days/12 months**]**

[Annual Enrollment Period: January 1 through January 31**]**

WEEKLY BENEFITS:

The **Weekly Benefit** will be **[**the lesser of:**]**
[[30-75%] of your Weekly Earnings; or**]**
[Option 1 ≥$25.00]
[Option 2 ≥$50.00]
reduced by Other Income Benefits.

Minimum Weekly Benefit: [The [greater/lesser**]** of:
[1) $[12-50- 50] or**]**
[2) [5-15]% of the Weekly Benefit before the deduction of Other Income Benefits**]**

In accordance with Arkansas state law, in no event however, will the Minimum Weekly Benefit be less than $12.50.

The **Maximum Duration of Benefits** for a Disability is:

[1) **[**0 - 6**]** weeks when the Pre-existing Condition Limitation applies; otherwise**]**

(2) **[**8-104**]** weeks.

Benefits Commence for Disability caused by:

Accident: on the **[**1st -60th**]** day of Total Disability

Sickness: on the **[**4th -60th**]** day of Total Disability

[For hospital confinements of 24 hours or more, benefits commence on the first day of hospital confinement.]

[Premium Rates

Initial Premium rates are guaranteed for [12-36] months. After the initial guarantee period, the monthly rates may change. Renewal rates are set based on Our underwriting criteria [and the experience of the group].]

DEFINITIONS

The terms listed if used will have these meanings:

Active Full-Time [Employee] - An **[**employee**]** who works for the Employer on a regular basis in the usual course of the Employer's business. Such **[**employee**]** must work the number of hours in the Employer's normal work week. This must be at least the number of hours for Full-Time Employment shown in the **[**Plan/Schedule**]** of Insurance.

Actively at Work - You will be considered to be actively at work with the Employer on a day which is one of the Employer's scheduled work days if you are performing, in the usual way, all of the regular duties of your job on a full time basis on that day. You will be deemed to be actively at work on a day which is not one of the Employer's scheduled work days only if you were actively at work on the preceding scheduled work day.

Current Weekly Earnings means the weekly earnings you receive from any employer or for any work while disabled and eligible for [Partial/Residual] Disability benefits under this plan.

Disability means Total **[**or Partial/Residual**]** Disability

Disabled means Totally **[**or Partially/Residually**]** Disabled

Employer means the Group Policyholder [a labor union/ a health & welfare trust fund/ or simply an employer] to which the Group Policy is issued. This certificate is issued subject to the terms of the Group Policy

Mental Illness means any psychological, behavioral or emotional disorder or ailment of the mind, including physical manifestations or psychological, behavioral or emotional disorder, but excluding demonstrable structural brain damage.

Other Income Benefits mean the amount of any benefit for loss of income, provided to you, [or to your family,] as a result of the period of Disability for which you are claiming benefits under this plan. This includes any such benefits for which you [or your family] are eligible, or that are paid to you, your family, or to a third party on your behalf. This includes the amount of any benefit for loss of income from:

(1) [The United States Social Security Act, The Civil Service Retirement System, The Railroad Retirement Act, the Jones Act, the Canada Pension Plan, the Quebec Pension Plan or similar plan or act that you, your spouse, or children are eligible to receive because of your Disability;
(2) any plan or arrangement of coverage, whether insured or not, as a result of employment by or association with the Employer, or as a result of membership in or association with any group, association, union or other organization;
(3) the Veteran's Administration or any other foreign or domestic governmental agency for the same Disability.
(4) any governmental law or program that provides disability or unemployment benefits as a result of your job with the Employer;
(5) individual insurance policy where the premium is wholly or partially paid by the Employer;
(6) any temporary or permanent disability benefits under a workers' compensation law,

occupational disease law, or similar law;
(7) compulsory "no-fault" automobile insurance;
(8) the portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for your loss of earnings.]

Other Income benefits will also include the amount of any benefits for loss of income from:
(1) the portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for your loss of earnings; or
(2) [compulsory "no-fault" automobile insurance].

Any general increase in benefits required by law that you are entitled to receive under any Federal Law will not reduce the Short Term Disability Benefit payable for a period of Total Disability that began prior to the date of such increase.

If you are paid Other Income Benefits in a lump sum, we will pro-rate the lump sum:
(1) over the period of time it would have been paid if not paid in a lump sum; or
(2) if such period of time cannot be determined, over a period of **[**260 - 520**]** weeks.

[Partial Disability or Partially Disabled means that immediately following a period of Total Disability, for which you were eligible to receive a Weekly Benefit, you are:
(1) still prevented by the same disabling condition from performing essential duties of your occupation; but
(2) you have recovered to the extent that you are
   a. able to perform some, but not all, of the essential duties of your **[**or any**]** occupation; and
   b. as a result, you are earning **[**more than [20-40]% but**]** no more than [60-80]% of your pre-disability Weekly Earnings.**]**

[Participant Employer means an employer whose employees are members of a [labor union/health & welfare trust fund] which is the Group Policyholder. An employee of a Participant Employer will be treated as an employee of the Group Policyholder/Employer for purposes of this policy.]

Physician means a practitioner of a healing art, which we are required by law to recognize, who is properly licensed, and practicing within the scope of that license.

[Residual Disability or Residually Disabled means that you are prevented by:
(1) accidental bodily injury;
(2) sickness;
(3) Mental Illness;
(4) Substance abuse; or
(5) pregnancy,

from performing some, but not all, of the essential duties of your [or any] occupation, and as a result, your Current Weekly Earnings are **[**more than [20-40]% but**]** no more than [60-80]% of your pre-disability Weekly Earnings.**]**

Sickness vs. Accident
A Disability shall be deemed to be caused by sickness, and not by accident if:

(1) it is caused or contributed to by:
    (a) any condition, disease or disorder of the body or mind;
    (b) any infection, except a pus-forming infection of an accidental cut or wound;
    (c) hernia of any type unless it is the immediate result of an accidental injury covered by this plan;
    (d) any disease of the heart;
    (e) Mental Illness;
    (f) Substance Abuse;
    (g) pregnancy; or
    (h) any medical treatment for items (a) through (g) above; or
(2) it is caused directly or indirectly by accident, but commences more than 30 days after the date of the accident;

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:
(1) impairments in social and/or occupational functioning;
(2) debilitating physical condition;
(3) inability to abstain from or reduce consumption of the substance; or
(4) the need for daily substance use to maintain adequate functioning.

Substance includes alcohol and drugs but excludes tobacco and caffeine.

Total Disability or Totally Disabled means that you are prevented by:
(1) accidental bodily injury;
(2) sickness;
(3) Mental Illness;
(4) Substance Abuse; or
(5) pregnancy,

from performing the essential duties of your occupation, **[**and as a result, you are earning less than [20-40]% of your pre-disability Weekly Earnings**]**.

[Weekly Earnings means your usual weekly rate of pay from the Employer, not counting:
(1) commissions;
(2) bonuses;
(3) overtime pay; or
(4) any other fringe benefit or extra compensation.

If you become Disabled, your Weekly Earnings will be the rate in effect on your last day as an Active Full-time [Employee] before becoming Totally Disabled.]

[Weekly Earnings means your usual weekly rate of pay, including commissions **[**and bonuses**]**, received from the Employer, but not:
(1) **[**bonuses**]**;
(2) overtime pay; or
(3) any fringe benefit or extra compensation.

Commissions **[**and bonuses**]** will be averaged as follows:
(1) over the most recent **[**12-36**]** month period prior to the date your disability began; or

(2) over the number of calendar months you worked for the Employer prior to becoming Disabled, if you have worked for the Employer at least 6 months but less than **[**12-36**]** months; or
(3) commissions **[**and bonuses**]** will not be included if you have worked for the Employer less than 6 months.

If you become Disabled, your Weekly Earnings will be the rate in effect on your last day as an Active Full-time [Employee] before becoming Totally Disabled.]

[Weekly Earnings means your usual rate of weekly pay, including commissions **[**and bonuses**]**, received from the Employer, but not:
[(1) bonuses;**]**
(2) overtime pay; or
(3) any fringe benefit or extra compensation.

If you are a commissioned sales person, your Weekly Earnings will be the weekly average of any salary or wages and commissions received from the Employer. This weekly average will be based on your Statement of Wages Earned and Taxes Withheld (Form W-2) for the year ending immediately prior to the date you became Totally Disabled.

If you become Disabled, your Weekly Earnings will be the rate in effect on your last day as an Active Full-time [Employee] before becoming Totally Disabled.]

We, **Our** or **Us** means Amalgamated Life Insurance Company

You means the Insured Person to whom this booklet-certificate is issued.

ELIGIBILITY AND ENROLLMENT

Who are Eligible Persons?
All persons in the class or classes shown in the [Plan/Schedule] of Insurance will be considered Eligible Persons.

When will you become eligible?
You will be eligible for coverage on either:
(1) the Plan Effective Date, if you have completed the Eligibility Waiting Period; or if not
(2) the date on which you complete the Eligibility Waiting Period.

See the [Plan/Schedule] of Insurance for the Eligibility Waiting Period.

[How do you enroll?
Eligible Persons will be enrolled automatically by the Employer **[**for Option 1**]]**.

[How do you enroll?
To enroll for **[**this plan/another Option**]**, you must:

(1) complete and sign a group insurance enrollment form which is satisfactory to us; and
(2) deliver it to the Employer**.]**

If you do not enroll within 31 days after becoming eligible, the following limitations will apply to a later enrollment:

[1) you must submit Evidence of Insurability satisfactory to us;**]**
[2) you may not enroll until:
(a) an Annual Enrollment Period; or
(b) you have a Change in Family Status.

Any such enrollment must be made during the Annual Enrollment Period or within 31 days of the Change in Family Status.

The dates of the Annual Enrollment Period are shown in the [Plan/Schedule] of Insurance.**]**

What constitutes a Change in Family Status?

A Change in Family Status means:

(1) your marriage; or
(2) the birth or adoption of a child or becoming the legal guardian of a child; or
[3 the death of or divorce from your spouse;**]** or
[4) the death of or emancipation of a child.**]**

What is Evidence of Insurability?

If you are required to submit Evidence of Insurability, you must:

(1) complete and sign a health and medical history form provided by us;
(2) submit to a medical examination, if requested;
(3) provide any additional information and attending physicians' statements that we may require; and
(4) furnish all such evidence at your own expense.

We will then determine if you are insurable under the plan.

When Coverage Starts

When does your coverage start?

[If you are not required to contribute towards the plan's cost, your coverage will start on the date you become eligible.**]**

[If you must contribute towards the plan's cost, your coverage starts on the date determined below:

(1) the date you are eligible, if you enroll or have enrolled by then;
(2) the date on which you enroll, if you do so within 31 days after the date you are eligible; or
[3) the [first - last] day of the month following the Annual Enrollment Period, if you

enroll during an Annual Enrollment Period;**]** or

(4) the date we approve your Evidence of Insurability, if you are required to submit Evidence of Insurability.**]**

Deferred Effective Date

Will coverage become effective if a disabling condition causes you to be absent from work on the date it is to start?

If you are absent from work due to your:

(1) accidental bodily injury;
(2) sickness;
(3) pregnancy;
(4) Mental Illness; or
(5) Substance Abuse,

on the date your insurance or increase in coverage would otherwise have become effective, the effective date of the coverage or increase in coverage will be deferred until you have been Actively at Work for one full work-day.

Changes In Coverage

Can you change benefit options?

You may change to an option providing increased or decreased benefits only:

[(1) during an Annual Enrollment Period; or]

(2) within 31 days of a Change in Family Status.

An increase in coverage **[**at any other time**][**that is greater than the next higher option**]** will be subject to your submission of Evidence of Insurability that meets our approval.

(Used only with Annual Enrollment Period plans)

[When will a requested change in benefit options take effect?

If you enroll for a change in benefit option during an Annual Enrollment Period, the change will take effect on the later of:

(1) the **[**first - last**]** day of the month following the Annual Enrollment Period; or
(2) the date we approve your Evidence of Insurability if you are required to submit Evidence of Insurability.]

If you enroll for a change in benefit option within 31 days following a Change in Family Status, the change will take effect on the later of:

(1) the date you enroll for the change; or
(2) the date we approve your Evidence of Insurability, if you are required to submit Evidence of Insurability.

Any such increase in coverage is subject to the limitations stated in the Deferred Effective Date provision [and the Pre-existing Conditions Limitations provision].

Do coverage amounts change if there is a change in your class or your rate of pay?
Your coverage may increase or decrease on the date there is a change in your class or Weekly Earnings. However, no increase in coverage will be effective unless on that date you:

(1) are an Active Full-time [Employee]; and
(2) are not absent from work due to being Disabled.

If you were so absent from work, the effective date of such increase will be deferred until you are Actively at Work for one full day.

No change in your Weekly Earnings will become effective until the date we receive notice of the change.

What happens if the Employer changes the Plan?
Any increase or decrease in coverage because of a change in the [Plan/Schedule] of Insurance will become effective on the date of the change, except that the limitations on increases stated in the Deferred Effective Date provision [and the Pre-existing Conditions Limitations provision] will apply.

DISABILITY BENEFITS

How do benefits become payable for Total Disability?
If, while covered under this Benefit, you become Totally Disabled, and furnish proof to us that you remain Totally Disabled, we will pay the Weekly Benefit shown in the **[**Plan/Schedule**]** of Insurance.

The amount of any Weekly Benefit payable shall be reduced by the total amount of all Other Income Benefits, including any amount for which you could collect but did not apply. **[**The benefit will be further reduced by any income received from **[**the Employer/any employer**]** for the period you are Totally Disabled

See the [Plan/Schedule] of Insurance for the Weekly Benefit, [Minimum Weekly Benefit], Maximum Duration of Benefits, and when Benefits Commence.

No benefits will be payable unless you are under the care of a Physician other than yourself **[**or a member of your immediate family. A member of your immediate family is your spouse, father, mother, brother, sister, son or daughter.**]**

[Partial Disability Benefit (#1)

How are benefits paid for Partial Disability?
After benefits have commenced for Total Disability, if you return to work on a part time or limited duty basis because you are Partially Disabled, the following calculation is used to determine your Weekly Benefit:

$$\text{Weekly Benefit} = \frac{(A - B)}{A} \times C$$

where

A = Your pre-disability Weekly Earnings.
B = Your Current Weekly Earnings.
C = The Weekly Benefit payable if you were Totally Disabled.]

[Partial Disability Benefit (#2)

How are benefits paid for Partial Disability?
After benefits have commenced for Total Disability, if you return to work on a part time or limited duty basis because you are Partially Disabled, the Weekly Benefit otherwise payable for Total Disability will be reduced by [25% - 50%] of your work earnings.

At no time may your benefit when combined with work earnings exceed 100% of your pre-disability Weekly Earnings.]

[Residual Disability Benefit (#1)

How are benefits paid for Residual Disability?
If while covered under this benefit, you become Disabled and work on a part time or limited duty basis because you are Residually Disabled, the following calculation is used to determine your Weekly Benefit:

$$\text{Weekly Benefit} = \frac{(A - B)}{A} \times C$$

where

A = Your pre-disability Weekly Earnings.
B = Your Current Weekly Earnings.
C = The Weekly Benefit payable if you were Totally Disabled.]

[Residual Disability Benefit (#2)

How are benefits paid for Residual Disability?
If while covered under this benefit, you become Disabled and work on a part time or limited duty basis because you are Residually Disabled, the Weekly Benefit otherwise payable for Total Disability will be reduced by **[**50-100**]**% of your work earnings.

[Your Weekly Benefit, however, will not be less than the Minimum Weekly Benefit shown in the [Plan/Schedule] of Insurance.**]**
[If you are participating in a program of Rehabilitative Employment approved by us, your Weekly Benefit will be determined by the Rehabilitative Employment Benefit**]]**

How is the benefit calculated for a period of less than a week?
If a Weekly Benefit is payable for less than a week, we will pay **[**1/7^{th,} 1/6^{th,} 1/5th**]** of the Weekly benefit for each day you were Disabled.

When will benefit payments cease?
Benefit payment will stop on the first to occur of:
(1) the date you are no longer Disabled;
(2) the date you fail to furnish proof that you continue to be Disabled;
(3) the date you refuse to be examined, if we require an examination;
(4) the last day benefits are payable according to the Maximum Duration of Benefits shown in the [Plan/Schedule] of Insurance; or
(5) the date you die.

Recurrent Disability

What happens to your benefits if you return to work as an Active Full-time [Employee] and then become Disabled again?
If you return to work as an Active Full-time [Employee] for [7-90] consecutive days or more, any recurrence of a disability will be treated as a new Disability with respect to when Benefits Commence and the Maximum Duration of Benefits, as shown in the [Plan/Schedule] of Insurance.

If recurrent periods of Disability are:
(1) due to the same or related cause; and
(2) separated by less than **[**7-90**]** consecutive days of work as an Active Full-time **[**Employee**]**, they will be considered to be the same period of Disability.

Multiple Causes

How long will benefits be paid if a period of Disability is extended by another cause?
If a period of Disability is extended by a new cause while weekly benefits are payable, Weekly Benefits will continue while you remain Disabled, subject to the following:

(1) Weekly Benefits will not continue beyond the end of the original Maximum Duration of Benefits; and
(2) the Exclusions [and Pre-existing Conditions Limitations] will apply to the new cause of Disability.

(Optional Benefit)
[Vocational Rehabilitation

What is Vocational Rehabilitation?

Vocational Rehabilitation means employment or services that prepare you, if Disabled, to resume gainful work.

Our Vocational Rehabilitative Services include, when appropriate, any necessary and feasible:
(1) vocational testing;
(2) vocational training;
(3) work-place modification;
(4) prosthesis; or
(5) job placement.]

[Rehabilitative Employment

Rehabilitative Employment means employment that is part of a program of Vocational Rehabilitation. Any program of Rehabilitative Employment must be approved, in writing, by us.

Do earnings from Rehabilitative Employment affect the Monthly Benefit?
If you are Disabled and are engaged in an approved program of Rehabilitative Employment, your Weekly Benefit will be:
(1) the amount calculated for Total Disability; but
(2) reduced by [25-70]% of the income received from each week of such Rehabilitative Employment.

The sum of your Weekly Benefit and total income received under this provision may not exceed 100% of your pre-disability Weekly Earnings. If this sum exceeds your pre-disability Weekly Earnings, the Weekly Benefit paid by us will be reduced proportionately.]

PRE-EXISTING CONDITIONS LIMITATION

Are benefits limited for a Pre-existing Condition?
The Maximum Duration of Benefits is limited as shown in the [Plan/Schedule] of Insurance. This limitation applies to any period of Disability that is due to, contributed to by, or results from a Pre-existing Condition, unless such Disability begins:
(1) after the last day of [5-730] consecutive days while insured during which you received no medical care for the Pre-existing Condition;
or
(2) after the last day of a [30-730] consecutive days during which you have been continuously insured under this plan.

What is a Pre-existing Condition?
A Pre-existing Condition is:
(1) any accidental bodily injury, sickness, Mental Illness, pregnancy, or episode of Substance Abuse; or
(2) any manifestation, symptom, finding, or aggravation related to or resulting from such accidental bodily injury, sickness, Mental Illness, pregnancy, or Substance Abuse;
for which you received Medical Care during the [90 - 365] day period that ends the day before:
(1) your effective date of coverage; or

(2) the effective date of a change in coverage.

Medical Care is received when:
(1) a Physician is consulted or medical advice is given; or
(2) Treatment is recommended, prescribed by, or received from a Physician.

Treatment includes but is not limited to:
(a) Medical examinations, tests, attendance or observation;
(b) use of drugs, medicines, medical services, supplies or equipment.

[Is there continuity of coverage from a Prior Plan?
If you become insured under the Group Insurance Policy on the Policy Effective Date and were covered under the Prior Plan on the day before the Policy Effective Date, the Pre-existing Conditions Limitation will cease to apply on the first to occur of the following dates:
(1) the Policy Effective Date, if your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Plan; or
(2) if your coverage was limited by a pre-existing condition restriction under the Prior Plan, the date the restriction would have ceased to apply had the Prior Plan remained in force.

Prior Plan, for the purpose of this provision, means:
1) a plan of group or blanket disability insurance; or
2) an employer-provided disability benefit arrangement, which provided disability benefits that are substantially similar to the short term disability benefits provided by this plan.]

[What is the Weekly Benefit for a Disability caused by such Pre-existing Condition?
The amount of the Weekly Benefit payable for a Pre-existing Condition that ceased to apply in accordance with the previous paragraph will be the lesser of:
(1) the Weekly Benefit that would have been paid by the Prior Plan; or
(2) the Weekly Benefit provided by this Plan.

No payment shall be made after the earlier to occur of:
(1) the date payments would have ceased under the Prior Plan; or
(2) the date payments cease under this Plan.]

[EXCLUSIONS

(Optional)

What Disabilities are not covered?

The Plan does not cover, and no benefit shall be paid for, any:

[(1)injury, sickness, Mental Illness, Substance Abuse, or pregnancy not being treated by a Physician or surgeon;

(2) Disability caused or contributed to by war or act of war (declared or not); or

(3) Disability caused by your commission of or attempt to commit a felony, or to which a contributing cause was your being engaged in an illegal occupation;

(4) Disability caused or contributed to by an intentionally self-inflicted injury;

(5) Disability unless it is the result of a work related sickness or injury sustained in the course of performing tasks for the Employer.

(5) sickness or injury for which workers' compensation benefits are paid, or may be paid, if duly claimed; or

(6) injury sustained as a result of doing any work for pay or profit for another employer.**]**

[If you are receiving, or are eligible to receive benefits for a Disability under a prior disability plan that:

(1) was sponsored by the Employer; and

(2) was terminated on the day before the Effective Date of this plan, then no benefits will be payable for the Disability under this plan.**]**

TERMINATION

When does your insurance terminate?

Your insurance will terminate on the earliest of:

(1) the date this plan terminates;

(2) the date this plan no longer insures your class;

(3) the date premium is due but not paid by the Employer;

(4) the last day of the period for which you make any required premium contribution, if you fail to make any further required contribution; or

[(5) the last day of the month immediately following the date your Employer terminates your employment; or]

(6) the date on which you cease to be an Active Full-time **[**Employee**]** in an eligible class, including:

(a) temporary layoff;

(b) leave of absence; or

(c) work stoppage (including a strike or lockout); or

(d) the date on which your Employer ceases to be a Participant Employer, if applicable.

(Optional)

[May coverage be continued during a family or medical leave?
If you are granted a leave of absence according to the Family and Medical Leave Act of 1993, the Employer may continue your insurance for up to 12 weeks, or longer if required by state law, following the date your coverage would have terminated, subject to the following:
(1) the leave authorization is in writing;
(2) the required premium for you is paid; and
(3) your benefit level, or the amount of earnings upon which your benefit may be based, will be that in effect on the day before said leave commenced; and
(4) such continuation will cease immediately if one of the following events should occur:
(a) the leave terminates prior to the agreed upon date;
(b) the termination of the Group Insurance Policy;
(c) non-payment of premium when due by the Policyholder or you;
(d) the Group Insurance Policy no longer insures your class; or
[e) your employer ceases to be a Participant Employer, if applicable.**]]**

(Optional)
[May your coverage be continued during a lay-off?
If you are temporarily laid off, the Employer may continue your insurance for [30 -365 days] **[**days/weeks/months/ years**]** following the month coverage would have terminated subject to the following:
(1) the required premium must be paid;
(2) your benefit level, or the amount of earnings upon which your benefits may be based, will be that in effect on the day before said layoff commenced; and
(3) such continuation will cease immediately if one of the following events should occur:
(a) the lay-off becomes permanent;
(b) the termination of the Group Insurance Policy;
(c) non-payment of premium when due by the Policyholder or you;
(d) the Group Insurance Policy no longer insures your class; or
[(e) your employer ceases to be a Participant Employer, if applicable.**]]**

(Optional)
[May your coverage be continued during a leave of absence?
If you are granted a leave of absence, the Employer may continue your insurance for [30 – 365 days] **[**days/weeks/months/ years**]** following the month coverage would have terminated subject to the following:
(1) the leave authorization is in writing, or is documented as a leave for military purposes;
(2) the required premium must be paid; and
(3) your benefit level, or the amount of earnings upon which your benefits may be based, will be that in effect on the day before said leave commenced; and
(4) such continuation will cease immediately if one of the following events should occur:
(a) the leave terminates prior to the agreed upon date;
(b) the termination of the Group Insurance Policy;

(c) non-payment of premium when due by the Policyholder or you;
(d) the Group Insurance Policy no longer insures your class; or
[e) your employer ceases to be a Participant Employer, if applicable.**]]**

Does your insurance continue while Disabled and no longer an Active Full-time [Employee]?
If you are no longer an Active Full-time [Employee] because you are Disabled, your Short Term Disability Insurance will be continued:
(1) while you remain Disabled;
(2) until the end of the period for which you are entitled to receive Short Term Disability Benefits.

After Short-Term Disability benefit payments have ceased, your insurance will be reinstated, provided:
(1) you return to work for one full day as an Active Full-time [Employee] in an eligible class;
(2) the Group Insurance Policy remains in force; and
(3) [the premiums for you were paid during your Disability, and continue to be paid][the required premium is paid].

[**Must premiums be paid during a Disability?**
No premium will be due for you for the period benefits are payable.]

Do benefits continue if the Group Insurance Policy terminates?
If you are entitled to benefits while Disabled and the Group Insurance Policy terminates, benefits:
(1) will continue as long as you remain Disabled by the same disabling condition, but
(2) will not be provided beyond the date we would have ceased to pay benefits had the insurance remained in force.

Termination of the Group Insurance Policy [or the Employer's participation in such policy] for any reason will have no affect on our liability under this provision.

GENERAL PROVISIONS

What happens if facts are misstated?
If material facts about you were not stated accurately:
(1) your premium may be adjusted; and
(2) the true facts will be used to determine if and for what amount, coverage should have been in force.

No statement made by you relating to your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during your lifetime. In order to be used, the statement must be in writing and signed by you.

When should we be notified of a claim?
You must give us written notice of a claim within 30 days after Disability starts. If notice cannot be given within that time, it must be given as soon as reasonably possible. Such notice must include your name, your address and the Policy number.

Are special forms required to file a claim?
When we receive a notice of claim, you will be sent forms for providing us with proof of loss. We will send these forms within 15 days after receiving a notice of claim. If we do not send the forms within 15 days, you may submit any other written proof which fully describes the nature and extent of your claim.

When must proof of loss be given?
Written proof of your Disability must be sent to us within 90 days after the start of the period for which we owe payment. After that, we may require further written proof that you are still Disabled. If proof is not given by the time it is due, it will not affect the claim if:
(1) it was not possible to give proof within the required time; and
(2) proof is given as soon as reasonably possible; but
(~~3~~) not later than 1 year after it is due, unless you are not legally competent~~.~~

We have the right to require, as part of the proof of loss:
(1) your signed statement identifying all Other Income Benefits; and
(2) proof satisfactory to us that you and your dependents have duly applied for all Other Income Benefits which are available.

May additional proof be required?
We may have you examined to determine if you are Disabled. Any such examination will be:
(1) at our expense; and
(2) as reasonably required by us.

We reserve the right to determine if your proof of loss is satisfactory.

Who gets the benefit payments?
All payments are payable to you. Any payments owed at your death may be paid to your estate. If any payment is owed to your estate, we may pay up to $1,000 to any of your relatives who is

entitled to it in our opinion. Any such payment shall fulfill our responsibility for the amount paid.

When are payment checks issued?
If written proof of loss is furnished, accrued benefits will be paid at the end of each week that you are Disabled. If payment is due at the end of a claim, it will be paid as soon as the written proof of loss is received.

What notification will you receive if your claim is denied?
If a claim for benefits is wholly or partly denied, you will be furnished with written notification of the decision. This written decision will:
(1) give the specific reason(s) for the denial;
(2) make specific reference to the policy provisions on which the denial is based;
(3) provide a description of any additional information necessary to prepare a claim and an explanation of why it is necessary; and
(4) provide an explanation of the review procedure.

What recourse do you have if your claim is denied?
On any claim, the claimant or his representative must appeal to Us for a full and fair review.

1. You must request a review upon written application within:
    a. 180 days of receipt of a claim denial if the claim requires a determination of disability; or
    b. 60 days of receipt of a claim denial for all other claims; and
2. You may request copies of all documents, records, and other information relevant to your claim; and
3. You may submit written comments, documents, records and other information relating to your claim.

We will respond in writing with our final decision on your claim.

When can legal action be started?
Legal action cannot be taken against us:
(1) sooner than 60 days after due proof of loss has been furnished; or
(2) later than the expiration of:
(a) 3 years; or if longer,
(b) the applicable Statute of Limitations;
from the time written proof of loss is required to be furnished according to the terms of the Policy.

What are our subrogation rights?
If you:
(1) suffer a Disability because of the act or omission of a Third Party; and
(2) become entitled to and are paid benefits under the Group Insurance Policy in compensation for lost wages; and
(3) do not initiate legal action for the recovery of such benefits from the Third Party in a reasonable period of time;

then we will be subrogated to any rights you may have against the Third Party and may, at our option, bring legal action to recover any payments made by us in connection with the Disability.

What happens if benefits are overpaid?
We have the right to recover from you any amount that is determined to be an overpayment of benefits under this plan. Repayment to us must be made within 60 days of your receipt of our notice of the amount of the overpayment. If you do not repay the overpayment within the 60 day period, we may, without forfeiting our right to collect an overpayment through any means legally available to us, recover all or any portion of the overpayment by reducing or withholding future benefit payments, including the Minimum Weekly Benefit, if applicable.

Who interprets policy terms and conditions?
We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Group Insurance Policy.

[Must one apply for Social Security Disability Benefits?
We may require that you apply for Social Security Disability Benefits if it appears that your Disability may meet the minimum duration required to qualify for such benefits. If the Social Security Administration denies your eligibility for any such benefits, you will be required to follow the process established by the Social Security Administration to reconsider the denial and, if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.**]**

SERFF Tracking Number:	*AMAL-126949636*	*State:*	*Arkansas*
Filing Company:	*Amalgamated Life Insurance Company*	*State Tracking Number:*	*48202*
Company Tracking Number:	*ALSTDP-AR-05*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*Group Short Term Disability Income*		
Project Name/Number:	*Group Short Term Disability /ALSTDP-AR-05*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	03/09/2011

Comments:

Attachment:

Readability Certification.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	03/09/2011

Comments:

These applications were previously approved by your Department (9/19/2010, SERFF# AMAL126774572) and will also be used to apply for coverage under this policy.

Attachments:

ALLIDIA-AR-10 final.pdf
ALLIDIE-AR-10 final.pdf
ALLIDIEOI-AR-10 final.pdf

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variable Language	Approved-Closed	03/09/2011

Comments:

Attachment:

MOVL-ALSTD-10(AR).pdf

		Item Status:	Status Date:
Satisfied - Item:	Previously approved applications	Approved-Closed	03/09/2011

Comments:

Approved by your Department (9/19/2010, SERFF# AMAL126774572).

Attachments:

ALLIDIA-AR-10 - Group Policy Application.pdf

SERFF Tracking Number:	*AMAL-126949636*	*State:*	*Arkansas*
Filing Company:	*Amalgamated Life Insurance Company*	*State Tracking Number:*	*48202*
Company Tracking Number:	*ALSTDP-AR-05*		
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Product Name:	*Group Short Term Disability Income*		
Project Name/Number:	*Group Short Term Disability /ALSTDP-AR-05*		

ALLIDIE-AR-10 - Life-Disability Enrollment Form.pdf

ALLIDIEOI-AR-10 - Evidence of Insurability Form.pdf

AMALGAMATED LIFE INSURANCE COMPANY

CERTIFICATION

Amalgamated Life Insurance Company has reviewed the enclosed forms(s) and certifies that the form(s) meet(s) the minimum flesch scale readability requirements of your State.

FORM	SCORE
ALSTDP-AR-05	49.9
ALSTDC-AR-05	47.7

Date: February 7, 2011

By: _____

Robert McCready
Assistant Vice President

AMALGAMATED LIFE INSURANCE COMPANY
333 Westchester Avenue, White Plains, NY 10604

GROUP INSURANCE APPLICATION

Application is hereby made to Amalgamated Life Insurance Company ("Amalgamated") on the basis of the data contained in this application, the group risk factors, the enrollment data and available experience data. The application in its entirety, and any required additional data, is subject to Amalgamated's approval before insurance can become effective.

If this application is approved by Amalgamated, it will be attached to and made part of the Group Polic(y)(ies). Insurance will become effective on the requested effective date shown below unless Amalgamated sends written notice of a different effective date.

If this application is not approved by Amalgamated, no insurance is in effect at any time and any deposit premium Amalgamated has received will be returned.

This application is made with the following deposit premium. The premium amount is estimated, as the amount due for the [first month]; and will be applied toward the first premium on the proposed Group Policy(ies); $ _____.

If any insurance requires employee contributions, any underwriting requirements for enrollment must be met before insurance can become effective. Requested effective date; _____.

Coverage(s) being applied for:

___ Life
___ AD&D Rider
___ Other Rider _____
___ Short Term Disability
___ Long Term Disability

W-2 Services Option (for Short Term Disability and Long Term Disability coverage only):

___ Option 1: Withhold state and federal income taxes and the employee's portion of FICA.
Prepare and file W-2 Forms.
___ Option 2: Withhold federal income taxes and the employee's portion of FICA.
Applicant waives W-2 Forms services.

A detailed description of the W-2 services elected by applicant pursuant to this application will be sent to the applicant via mail. Such services will be performed in accordance with the above election and established standard procedures.

Are there any companies that are subsidiaries or affiliates of the applicant, which are also to be insured?
____ Yes ____ No If yes, please furnish a listing, giving the name, address, effective date of coverage, and number of employees for each such company.

Is the benefit plan, for which insurance is being requested, subject to the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended? ____ Yes ____ No
If yes, identify the Plan Number: _____

Sales Representative for Amalgamated: _____

Regional Office: _____ Name of Agent/Broker: _____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

***For Applicant**:*

_____
Legal Name of Entity

_____ _____
Signature Date

_____ _____
Name and Title of Authorized Signature. Employer Tax Id No.

AMALGAMATED LIFE INSURANCE COMPANY
333 Westchester Avenue White Plains, New York 10604
LIFE INSURANCE AND DISABILITY ENROLLMENT FORM

☐ Initial ☐ Change ☐ Termination ☐ Reinstatement

TO BE COMPLETED BY THE EMPLOYEE

Name Last	**First**	**M.I.**	**Birth Date: MM/DD/YY**

Social Security No.	**Sex** ☐ **M** ☐ **F**	**Marital Status** ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced	**Date of Marriage**: **MM/DD/YY**

Employee Home Address Street	**City**	**State**	**Zip**

Dependent Information (complete only if coverage is available & elected) (Dependent Life only)

	Last	**First**	**M. I.**	**Sex: M/F**	**Birth Date: MM/DD/YY**
Spouse					
Child					
Child					
Child					

Indicate type of coverage below. You may only elect coverages reflected in your Employer's contract. (*You will not be covered for coverages not included in your Employer's contract*.) To elect coverage check the box marked "Y". To decline coverage check the box marked "N"

Basic Life ☐Y ☐N Amt $_____	**Supp Life** ☐ Y ☐ N Amt $_____ Basic Income $_____ Other	**AD/D** Rider ☐ Y ☐ N **Other Rider** (please specify) _____ _____	**[Weekly] Disability** ☐Y ☐N Flat Amt $_____	**LTD** ☐ Y ☐ N Amt $_____

Dependent Life Spouse ☐ Y ☐ N Amt $_____ Child ☐ Y ☐ N Amt $_____	**Supplemental Life** ☐ **Y** ☐ N	**LTD Buy-Up** Option 1 _____% Option 2 _____%

Beneficiary Designation - Please refer to the reverse side for important information regarding beneficiary designation.

Full Name Address SSN Relationship DOB

Primary _____

Contingent _____

☐ I hereby apply for the coverages I have indicated above on behalf of myself and all dependents listed. I authorize my employer to make the appropriate deductions, if any, from my wages to pay for my share of the cost. I understand that the coverages available to me are in accordance with the provisions of the contract between Amalgamated Life and my Group Plan.

☐ I hereby waive coverages offered to me. I understand that if I desire to apply for any of these coverages at a later date, I will be required to furnish, at my own expense, medical evidence in support of insurability that is satisfactory to Amalgamated Life, before my coverage will become effective.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature _____ **Date** _____

TO BE COMPLETED BY THE EMPLOYER

Policy Symbol	Policy Number	Bill Unit	Loss Unit	Original Effective Date of Policy
Employer Name	Employee Hire Date	Effective Date of Coverage		
Employee Occupation	Employee Class	Life [Weekly] Disability LTD		
Salary $_____ ☐Annual ☐Monthly ☐Weekly ☐Hourly				
Termination Date		Reinstatement Date		

NAMING YOUR BENEFICIARY

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number, relationship and, if a minor, the age of that minor. If the beneficiary is not related either by blood or marriage insert the words, **"Not related."** If you need assistance, contact your company representative or your own legal counsel.

Following are examples of the most common designations:

Mary J. Doe, Wife (not Mrs. John Doe).

Mary J. Doe, Wife, if living, otherwise to Joseph W. Doe, Son.

Mary J. Doe, Wife, if living, otherwise to Jane Doe, Daughter, and Joseph W. Doe, Son, in equal shares or to the survivor.

Estate of the Insured

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example "1/3 to Mary Jones, Mother and 2/3 to Edith Jones, Wife."

If you find that more space is needed for naming your beneficiary(ies) than provided on this form please attach a separate sheet(s). Sign and date each sheet.

AMALGAMATED LIFE INSURANCE COMPANY
333 Westchester Avenue White Plains, NY 10604

EVIDENCE OF INSURABILITY FORM

[Applicants] must complete this form if they have requested insurance coverage for themselves [or any of their family members] and are required to show evidence of good health. For questions about how to complete this form, call Amalgamated Life Insurance Company (the "Company") at **[1-800-331-7234]**

Upon Completion: Send [both the [Policyholder] and [Applicant] sections of] this form to:
Amalgamated Life Insurance Company
Group Life & Health Insurance Underwriting
[P.O. Box 2999, Amalgamated, CT 06014-2999]

Please remember your form can not be processed without your signature and current date.
Please keep a copy of the completed forms for your records.

Check Applicable Coverage	☐ **Life Insurance**	☐ **Short Term Disability**	☐ **Long Term Disability**

[INSTRUCTIONS

[[Policyholder's] Responsibility

1. Fill out the [Policyholder] Section completely. Please note an incomplete form will result in a delay in processing your request for insurance. Refer to your Policy and employee records. [These records are your property and are not on file with the Company's Group Medical Underwriting Unit.]
2. In Section #1 of this [application] form ("Who Requires an [Application]?") indicate with a check mark all who are required to provide evidence of good health – [employee, spouse or child- and for each,] and check the reason(s) why. Refer to your Policy and employee records for all requirements, limitations and exceptions. Employees or spouses signing up after their new hire eligibility period will be responsible for any underwriting costs.
3. In Section (#2 "Coverage Summary,") complete all coverage amounts for each [Applicant]. **[Basic Life Coverage is important and required for all [Applicants] requesting additional Life coverage.]** refer to your employee records to find current coverage amounts. Please note that the Company does not have access to employee records for coverage amounts.
4. Complete the [Policyholder] section and forward the entire form to the employee who needs evidence of insurability.
5. No premiums should be deducted for additional amounts until a final decision regarding coverage is received from the Company's Underwriting Unit.**]**

[[Applicant's] Responsibility

1. [Make sure your Employer has already completed the [Policyholder] Section of this form in full.]
2. [The [Policyholder] Section clarifies which [Applicants] need to show evidence of good health and should be listed on this [application] form. Refer to ("Who Requires an [Application]?") in the **[Policyholder] Section** of the form where a box has been marked for each person who is required to fill out this [Application] form - [you (the employee), your spouse or child.] Enter the names of these individuals on the [Application] under "[Applicants] Requiring Health Evaluation," and fill in the information requested.]
3. Answer all questions completely and accurately. Even minor details like height and weight are very important and must be accurate.
4. An [Applicant] who has not enrolled by the end of the new hire eligibility period (shown in the [Policyholder] Section #1) will be responsible to pay for the cost of physical exams, medical records or medical tests if they are required during the underwriting process.
5. YOU, THE [EMPLOYEE] MUST SIGN THIS FORM (even if you yourself are not applying for coverage). Use your full legal signature, and enter the date signed. [Your spouse must sign this form ONLY if using this form to apply for coverage. He or she must use a full legal signature and enter the date signed.]
6. **[BOTH THE [EMPLOYER] AND [EMPLOYEE] SECTIONS OF THIS FORM MUST BE COMPLETED AND RECEIVED BY THE COMPANY WITHIN [30 DAYS] OF THE SIGNATURE DATE.]**
7. The medical and personal information you complete on this form will be considered "current" for [90 days]. Leaving information blank can result in delays or may result in your file being closed.

]

[POLICYHOLDER INFORMATION

[Policyholder] Section Please print in blue or black ink. Initial any changes. Do Not Erase			
[Policyholder] Name:			
[Division/Subsidiary Name:]			
[Participating Organization:]			
[Policy No.]			
[Certificate No.]			
[Policy Effective Date]			
[Mailing Address: Street:	City:	State:	Zip Code:]
[Benefits Contact Person (If Applicable): Telephone Number:		E-Mail:]	
[[Applicant] Name/[Applicant] Social Security Number/Date of Hire/Family Status Change Date/[Applicant] Base Annual Earnings (BAE)$]			

]

PROPOSED INSURED INFORMATION

[Applicant]/Proposed Insured Information Section Please print in blue or black ink. Initial any changes. Do Not Erase	
Answer all the questions. DATE and SIGN this form in all areas indicated	Mail the completed [Policyholder] and [Applicant] section(s) to: Amalgamated Life Insurance Co. Group Life & Health Ins. Underwriting [P.O. Box 2999 Amalgamated, CT 06104-2999]

[Applicant's] Name (First, Middle Initial, Last)			
☐Male ☐Female			
Height:___ft. ___in			
Weight: _____lb.			
Social Sec. No.:			
Mailing Address: Street:	City:	State:	Zip Code
Phone Number (Daytime/Evening):			
Date of Birth:			
[Age Last Birthday:]			
Place of Birth: (Town, State, Country)			
[Occupation/Title:]			
[Position/Duties:]			
[Date of Hire]			
Effective Date			
[Business Address: Street:	City:	State:	Zip Code:]
[E-Mail:]			
[Can we call you for any additional or missing information? YES: ☐ NO ☐What is the best time to call you?]			
[Business Telephone:]			

[1.Who requires an [Application]
Check box for each [Applicant] who requires evidence of good health with an [Application], and specify the reason(s) why.
Check all reasons that apply. Identify all [Applicants] requiring an [Application].

[IEE Employee	☐**New Hire** Newly hired employee electing coverage for the first time during normal eligibility period.*	☐**Over Guaranteed Issue ("GI") Limit** Election being made that requires medical underwriting, as it is above the GI limit*	☐**Opting up to Higher Level of Coverage** e.g. from 1 to 2 times salary or increasing in specified incremental dollar amounts as allowed by the plan.*	☐**Late Entrant** Employee who enrolled outside one of the following eligibility periods, usually 31 days from date of hire or from date of family status change, or an open enrollment.*	☐**Change in Family Status** Employee change in coverage being made within 31 days of a qualified change in family status.* (marriage, divorce, birth of a child, etc)**]**
[SP Spouse	☐**New Hire** Spouse electing coverage for the first time with a newly eligible employee during normal eligibility period.	☐**Over Guaranteed Issue Limit** Election being made that requires medical underwriting, as it is above the GI limit.*	☐**Opting up to Higher Level of Coverage** e.g. from $10,000 to $20,000 in coverage.*	☐**Late Entrant** Spouse did not enroll during one of the following eligibility periods: usually 31 days from employee date of hire or from date of family status change*	☐**Change in Family Status** Newly eligible spouse qualifies for GI coverage if elected within 31 days of the change in family status.***]**
[CH Child	☐**New Hire** Child electing coverage for the first time with a newly eligible employee during normal eligibility period.	☐**Over Guaranteed Issue Limit** Election being made that requires medical underwriting, as it is above the GI limit.*	☐**Opting up to Higher Level of Coverage** e.g. from $10,000 to $20,000 in coverage.*	☐**Late Entrant** Child did not enroll during one of the following eligibility periods: usually 31 days from employee date of hire or from date of family status change.*	☐**Change in Family Status** Newly eligible child qualify for GI coverage if elected within 3 1 days of the change in family status.***]**

*Please Refer to your policy and employee records for coverage amounts, eligibility periods (for Late Entrant determination), Guaranteed Issue limits, exceptions for salary increases and rules for "opting up." Please check the policy guidelines for Change in Family Status rules and exceptions. **]**

[

[Applicants] Requiring Health Evaluation (This is critical information and if left blank there will be a delay in processing.) List below the names of [Applicants] identified in Section 1.								
First Name, M.I., Last Name	**[APPLICANTS]**	**HEIGHT (ft/in) Required**	**WEIGHT (lbs) Required**	**DATE OF BIRTH Required Month**	**Day**	**Year**	**GENDER**	
[	[Applicant]						M	F]
[	Spouse						M	F]
[	Child						M	F]

]

[

If Dependent Coverage is desired, complete the following:				
Full Name	Relationship	Birth Date	Height	Weight

]

[OTHER INSURANCE INFORMATION

Does anyone proposed for coverage have any [Life/Disability Income] Insurance in force or pending with this or any other company? ☐Yes ☐No If yes, give details:

Name	Company	Face Amount	Monthly Benefit	Benefit Period	Waiting Period	To be replaced? Yes	No

]

[Please check "Yes" or "No" By applying for this insurance, do you intend to replace, discontinue, or change an existing policy of life insurance? ☐Yes ☐No **]**

[COVERAGE REQUESTED

[COVERAGE REQUESTED: ☐ New Coverage ☐ Change in Coverage

Disability Income

[Weekly] Benefit Amount: _____ Payment Period Option: _____ Waiting Period Option: _____

Is the [Weekly] Benefit Amount herein applied for equal to or less than [60%] of your Basic [Weekly] Pay minus any Other Income Benefits? ☐ Yes ☐ No **]**

[Life Insurance Amount Desired ([$10,000] minimum up to [$100,000] maximum in [$10,000] increments) _____

_____
[Proposed Insured]

[_____
Spouse

Please indicate if request is for ☐New Coverage

☐Change in Coverage

The Spouse may not be covered under a Plan with benefits greater than the Member's Plan.]

[IF REQUEST IS TO CHANGE EXISTING COVERAGE, PRINT ONLY THE ADDITIONAL AMOUNT DESIRED]

]]

[2. Coverage Summary - For each [Applicant,] complete all three columns

[Life Coverages: Be sure to include any in force Basic Life coverage as a dollar amount for all [Applicants] requesting supplemental life coverage. Refer to employee records for Current Coverage Amounts. For most policies, Life coverage can be calculated as 1, 2, 3 etc. times salary or in dollar amount increments for increment plans.**]**

[[Applicants] for Life Coverage	**Current Coverage Amount** *(This includes any GI coverage if eligible. This would apply to new hires electing for the first lime. If late entrant this amount should be zero)*	**Additional Amount Applied For** *(This amount reflects only the amount to be medically underwritten)*	**Total Coverage** *(Combined total of the amount currently in force and the amount being underwritten)*
Employee: Basic Life Salary multiples for BAE plans	**Required if Basic Coverage offered** **$__,__ __ __, __ __ __** ☐**1x** ☐ **2x** ☐ **3x** ☐ **4x** ☐ **5x** **_____x Other multiple**	**$__,__ __ __, __ __ __** ☐**1x** ☐ **2x** ☐ **3x** ☐ **4x** ☐ **5x** **_____x Other multiple**	**$__,__ __ __, __ __ __** ☐**1x** ☐ **2x** ☐ **3x** ☐ **4x** ☐ **5x** **_____x Other multiple**
Employee: Supplemental Life or Voluntary Life Salary Multiples for BAE	**$__,__ __ __, __ __ __** ☐**1x** ☐ **2x** ☐ **3x** ☐ **4x** ☐ **5x** **_____x Other multiple**	**$__,__ __ __, __ __ __** ☐**1x** ☐ **2x** ☐ **3x** ☐ **4x** ☐ **5x** **_____x Other multiple**	**$__,__ __ __, __ __ __** ☐**1x** ☐ **2x** ☐ **3x** ☐ **4x** ☐ **5x** **_____x Other multiple]**

[Coverage Summary (continued from previous page)]			
[[Applicants] for Life Coverage	**Current Coverage Amount** *(This includes any GI coverage if eligible. This would apply to new hires electing for the first time. If late entrant this amount should be zero)*	**Additional Amount Applied For** *(This amount reflects only the amount to be medically underwritten)*	**Total Coverage** *(Combined total of the amount currently in force and the amount being underwritten)*
[Spouse: Basic Life	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __**
Supplemental Life or Voluntary Life	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __]**
[Child: Basic Life	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __**
Supplemental Life or Voluntary Life	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __]]**
[Long Term Disability Coverage: Refer to employee records for the benefit percentage selected and calculate that percentage of their annual salary. Then calculate the monthly benefit amount by dividing by 12. **]** **[Short Term Disability Coverage:** Refer to employee records for the benefit percentage selected and calculate that percentage of their annual salary. Then calculate the weekly benefit by dividing by 52.**]**			
[[Applicants] (employees only)	**Current Benefit Amount**	**Additional Benefit Amount**	**Total Benefit Amount**
[Employee: Long Term Disability	**$___ ___, ___ ___ ___ per month**	**$___ ___, ___ ___ ___ per month**	**$___ ___, ___ ___ ___ per month]**
[Employee; Short Term Disability	**$___ ___, ___ ___ ___ per week**	**$___ ___, ___ ___ ___ per week**	**$___ ___, ___ ___ ___ per week]]**

]

[The following costs were calculated based on your age as of [January 1, 2009], your [annual salary of $50,000] and [12 (Monthly) deductions]. Your employer gave this information to the Company. Please contact your benefits administrator immediately if it is incorrect.

[Voluntary Long Term Disability Insurance

You have the opportunity to enroll in [the Company's Voluntary Long Term Disability (LTD) insurance plan]. LTD insurance helps to replace your income if you are sick or injured and cannot work and is designed to begin after you have been Disabled for a predetermined waiting period, known as the elimination period, of [180 days]. This plan provides you with income protection to replace up to [60%] of your regular pay, to a maximum monthly benefit of [$5,000].

☐ I **elect** to enroll in the Voluntary LTD plan at a [monthly] cost of [$ 1.00.*]
☐ I **decline** to enroll in the Voluntary LTD plan.

*Your cost may change if your salary changes within the benefits plan year.**]**

[The following costs were calculated based on your age as of [January 1, 2009] and [12 (Monthly) deductions.] Your employer gave this information to the Company. Please contact your benefits administrator immediately if it is incorrect.

[Voluntary Short Term Disability Insurance

You have the opportunity to enroll in [the Company's Short Term Disability (STD) insurance plan.] STD insurance helps to replace your income if you are sick or injured and cannot work. This coverage commences on the [1st] day of accident and the [8th] day of sickness and is designed to continue for a period of [13] weeks.] This plan provides you with income protection to replace up to [60%] of your earnings, to a maximum pay period benefit of [$1,000.]
☐ I **elect** to enroll in the Voluntary STD plan at a [weekly] cost of [$1.00.*]
☐ I **decline** to enroll in the Voluntary STD plan.
*Your cost may change if your salary changes during the plan year.**]**

[Supplemental Life Insurance – Employee

You have the opportunity to enroll in [the Company's Supplemental Life Insurance plan.] Your election may be made in increments of [$10,000], not to exceed [3] times your salary or [$350,000], whichever is less. If you elect an amount that exceeds the lesser of [3] times your salary or the guaranteed issue amount of [$100, 000,] you will need to provide evidence of good health that is satisfactory to the Company before the excess benefit can become effective. The guaranteed issue amount may increase as it is subject to the final level of participation in this plan. Monthly costs, based on your age, are shown below.*

[Employee Life Amounts*	Monthly Cost*	Employee Life Amounts*	Monthly Cost*
$10,000	$0.50	$60,000	$3.00
$30,000	$1.50	$80,000	$4.00
$50,000	$2.50	$100,000	$5.00**]**

To determine the cost for Supplemental Life coverage in excess of [$100,000], add the cost of insurance for [$100,000] to the amount over [$100,000] that you wish to elect. For example, to calculate the cost for [$150,000], add the monthly cost for [$100,000] of coverage to the monthly cost for [$50,000] of coverage.]

☐ I **elect** to enroll in the Supplemental Life Insurance plan for $_____ at a monthly cost of $_____.
Employee Life Amount*

☐ I **decline** to enroll in the Supplemental Life Insurance plan.

[***NOTE**: Benefit reductions begin at age [65.] If you are or over age [65], the monthly costs shown are calculated based on your reduced benefit amount, not the employee life amount shown. Please see your benefits administrator for further information.] **]**

[Supplemental Life Insurance – Spouse

If you elect the Supplemental Life Insurance plan for yourself, you may elect Supplemental Life Insurance coverage for your Spouse. Your election may be made in increments of [$5,000] to a maximum of [$50,000] but may not exceed 50% of your approved election. If you elect an amount that exceeds the guaranteed issue amount of [$25,000], your spouse will need to provide evidence of good health that is satisfactory to the Company before the excess benefit can become effective. Use the rate chart and calculation line below to determine your Monthly cost for this coverage. Supplemental Spouse rates and premiums are based on the [employee's age, not the Spouse's age.]

[Spouse Life Amounts*	Monthly Cost*	Spouse Life Amounts*	Monthly Cost*
$5,000	$0.25	$30,000	$1.50
$15,000	$0.75	$40,000	$2.00
$25,000	$1.25	$50,000	$2.50**]**

☐ I **elect** to enroll in the Supplemental Life Insurance plan for $ _____ at a monthly cost of $ _____.*
Spouse Life Amount

☐ I **decline** to enroll in the Supplemental Life Insurance plan for my Spouse.

*Your cost may change if your age category changes during the benefit plan year.

SPOUSE

First Name	Last Name	Gender	Date of Marriage	Date of Birth	Benefit Amount

]

[Supplemental Life Insurance - Child(ren)

If you elect the Supplemental Life Insurance plan for yourself, you may elect Supplemental Life coverage for your Dependent Child(ren) from [date of birth] to [19] years ([23] years if a full time student). You may elect in increments of [$500] to a maximum of [$25,000] but you may not exceed [50%] of your approved election. Use the calculation line to determine your monthly cost for this coverage.

[Child Life Insurance Amount	$2,000	$4,000	$6,000	$8,000	$10,000
Cost per Child	$0.10	$0.20	$0.30	$0.40	$0.50**]**

☐ I **elect** to enroll my dependent child(ren) in the Supplemental Life plan for $ _____ at the monthly cost below.

# of Children	X	Cost Per Child Above	=	$ Your Monthly Cost
_____		_____		_____

☐ I **decline** to enroll in the Supplemental Life Insurance plan for my dependent child(ren).

CHILD(REN):

First Name	**Last Name**	**Gender**	**Date of Birth**	**Benefit Amount**

]

[BENEFICIARY INFORMATION

Beneficiary Designation

It is important that your beneficiary designation be clear so there will be no question as to your intent. It is also important that you name a primary and [contingent] beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number, relationship to you, date of birth and distribution percentage. If the beneficiary is not related either by blood or by marriage, insert the words, "Not Related" next to their stated relationship. If you need assistance, contact your benefits administrator or your own legal counsel. Following are examples of the most common designations:

Primary:	[Contingent]:
● Mary J. Doe, Wife (not Mrs. John Doe).	● Joseph W. Doe, Son and Jane Doe, Daughter, in equal shares 50%). ● Estate of the Insured

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example "33% to Mary Jones, Mother, and 67% to Edith Jones, Wife."

	Full Name	Address	SSN	Relationship	D.O.B.	%
Primary						
[Contingent]						**]**

[The beneficiary for life insurance on the lives of your spouse and/or children will automatically be you, if surviving, otherwise the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon your written request.)

Beneficiary - Print full name & relationship to you
Name _____ Relationship _____

The Proposed Insured will be the beneficiary for any Dependent Coverage desired. **]**

HEALTH INFORMATION

Health Questions

For all "YES" answers check Yes. For all "NO" answers check No.

[PLEASE ANSWER THE FOLLOWING AND GIVE DETAILS OF ALL "YES" ANSWERS BELOW:]

[If you are under age 75 please answer **all** of the following questions. **If you are age 75 or over, please answer** [all question(s)/questions marked [A1, B2, C1, D2, E1 thru E5]]]

[A1. [Has anyone proposed for coverage] been actively engaged in the full-time duties of [his/her/your] occupation during the [90 day] period immediately before the date of this [application]? [You: ☐ Yes ☐ No] [Spouse: ☐ Yes ☐ No] **]**

[A2. At any time during the past [12 months], [has anyone proposed for coverage] smoked cigarettes, cigars, or used a pipe, chewing tobacco, nicotine chewing gum or snuff? [You: ☐Yes ☐ No] [Spouse: ☐ Yes ☐ No] **]**

[To the best of the [Applicant's] knowledge and belief during the past [10 years] has any of the [Applicants] at any time been treated or consulted a physician for or told they have a problem with any of the following:	**YES**	**NO**
B1. [Abnormal pulse		
B2. Alcoholism		
B3. Anemia or other blood conditions		
B4. Anxiety		
B5. Any disease or disorder of the brain or nervous system		
B6. Any disease or disorder of the digestive system		
B7. Any disease or disorder of the glands		
B8. Any disease or disorder of the heart, blood or circulatory system		
B9. Any disease or disorder of the lungs or respiratory system		
B10. Any disease or disorder of the skin, bones, or joints, including neck or back disorders		
B11. Arthritis		
B12. Asthma		
B13. Blood or circulatory or vascular conditions		
B14. Blood or sugar in urine		
B15. Bronchitis		
B16. Cancer		
B17. Chest pain		
B18. Colitis		
B19. Diabetes		
B20. Dizziness		
B22. Drug or alcohol or nicotine use on a regular basis - Indicate amount used daily		

(Continued from previous page)		
	YES	NO
B23 Eating disorder		
B24. Elevated cholesterol		
B25. Enlarged lymph nodes or glands		
B26 Epilepsy		
B27. Eyes, ears, nose or throat – chronic		
B28. Gallbladder		
B29. Genital or reproductive organ problems		
B30. Heart condition		
B31. Heart murmur		
B32. Hepatitis		
B33. High blood pressure		
B34. Immune system - except HIV		
B35. Impaired sight or hearing		
B36. Insulin dependent diabetes		
B37. Intestines		
B38. Kidney disease		
B39. Kidneys, bladder, or urinary tract – chronic		
B40. Leukemia		
B41. Liver		
B42. Mental or Nervous disorders, including depression		
B43. Paralysis		
B44. Pneumonia		
B45. Psychiatric		
B46. Rectum		
B47. Recurrent or chronic sleep disorders/apnea		
B48. Respiratory problems		
B49. Rheumatism		
B50. Severe headaches		
B51. Shortness of breath		
B52. Skin disorders, moles, melanoma, basal cell carcinoma		
B53. Spleen		
B54. Stomach		
B55. Stroke		
B56. Thyroid		
B57. Tuberculosis		
B58. Tumor		
B59. Ulcer		
B60. Upper or lower digestive system **]**		
[C1. To the best of the [Applicant's] knowledge and belief, [Has anyone proposed for coverage] ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder except for HIV?**]**		
[C2. To the best of the [Applicant's] knowledge and belief, during the past [5 years] [has anyone proposed for coverage] consulted any physician, surgeon, psychologist, psychiatrist or other practitioner for any reason not previously noted on this [application]; or been confined or treated in any hospital, sanatorium or similar institution? **]**		

[ADDITIONAL QUESTIONS:	YES	NO
To the best of the [Applicant's] knowledge and belief, during the past [10 years] [has anyone proposed for coverage]:		
[D1. Had surgery or been told to have surgery?]		
[D2. Been in a hospital or other institution for diagnosis or treatment?]		
[D3. Had any injuries from a car accident, or filed a Worker's Compensation claim?]		
[D4. Been declined for any life or disability insurance coverage?]		
[D5. Consulted or been examined by any healthcare provider for anything other than normal physical exams or acute illness such as cold, flu or sore throat?]		
[D6. Had any lab tests, x-ray, electrocardiogram or other diagnostic testing other than those requested as part of routine physical with normal findings?]]		

[E1. To the best of the [Applicant's] knowledge and belief, during the past [2 years] [has anyone proposed for coverage] been hospitalized for any condition?]		
[E2. To the best of the [Applicant's] knowledge and belief, [has anyone proposed for coverage] been confined in a hospital, nursing home, sanatorium or similar institution due to illness in the past [6 months?]]		
[E3. To the best of the [Applicant's] knowledge and belief, [is anyone proposed for coverage] **currently** pregnant? [If yes, Name: _____ When is the baby due? _____ Are there any medical complications? _____ What was your pre-pregnancy weight?]_____]		
[E4. [To the best of the [Applicant's] knowledge and belief, [is anyone proposed for coverage] taking medication for any condition or disease?]		
[E5. To the best of the [Applicant's] knowledge and belief, are there any symptoms, injury, birth defect, congenital defect, disease or other disorder not mentioned above? Please list all.]		

(All Inclusive Additional Information)

If you answered "Yes" to any of the above questions, please explain the details. An additional sheet of paper may be used, if necessary.

Question Number	Name	Disorder or Reason	Dates To/From	Give details for any "Yes" answer. Explain nature of illness, number of attacks, duration, severity, treatment, names & addresses of physicians, hospitals, & date of full recovery.

(Individual Additional Information — May Follow Each Question)

[Applicant] name(s):	Question Number	Medical condition:	Date treatment started: Date admitted: Date discharged:
Treatment/Medication:	Date of last treatment:		Current Status:
Physicians name and complete address:			
Please provide Primary Care Physician's name and complete mailing address:			
			]

[Simplified Medical Underwriting Questions

During the past [5 years] have you been treated, diagnosed or received medical advice for a heart attack, stroke, cancer, back, muscle, joint or mental nervous disorders or Acquired Immune Deficiency Syndrome (AIDS)?

[Applicant] ☐ Yes ☐ No [Spouse ☐ Yes ☐ No] [Child ☐ Yes ☐ No]

Please review your answer to this question to be sure that you have answered it fully and truthfully. Answering "No" to this question will qualify you for coverage. Answering "Yes" to this question disqualifies you from automatic acceptance for coverage at this time. However, if you feel you have recovered or are no longer requiring medical services, you may ask for reconsideration by completing [an Application.] Please contact [your Human Resources department for this form.] **]**

I have read this completed application and represent that to the best of my knowledge and belief all statements and answers herein are complete, true and correctly recorded. All statements made by, or by the authority of, the applicant for the issuance, reinstatement or renewal of any such policy or contract shall be deemed representations and not warranties.

I also understand that although any misrepresentation contained herein or relied upon by the company will not render the contract void, such misrepresentation may be used to contest the validity of the coverage in a court of law, within the contestable period if such misrepresentation materially affects acceptance of the risk. This information may be used by the Company for plan administration purposes to decide if the person(s) is/are eligible for coverage.

Subject to the deferred effective date provision I understand that coverage will not become effective until the Company grants its underwriting approval. I do not receive temporary or conditional insurance coverage just because I submit an [application] and pay the first premium.

I certify that I have received the Notice of Insurance Information Practices. I agree that this document and all its contents shall form a part of my enrollment request for group benefits.

[[Applicant] Confirmation

I have been given the opportunity to enroll in [ABC Company's LTD Group plan effective June 1, 2002]. I understand that if I decline now, but later decide to enroll, I will be required to provide evidence of good health that is satisfactory to the Company and understand my request for coverage may be denied.

I authorize my employer to make the appropriate payroll deductions from my wages [on a post-tax basis.] I am not now disabled and I am performing all the duties of my occupation on a full-time basis. [My spouse is either actively at work or, if not employed, able to carry on all the normal and customary activities of a person of like age and sex in good health.]

I am aware that if participation requirements are not met, this plan will not be implemented and the coverage elected will not be in force. **]**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Please print [Applicant] Full Name (First and Last):			**[Please print Spouse's Full Name (First and Last)]**	
[APPLICANT'S] SIGNATURE (**required**) or Legal representative to [Applicant]	DATE SIGNED Relationship:	[OR	SPOUSE'S SIGNATURE (required only if applying for coverage)	DATE SIGNED**]**

[AUTHORIZATION

I authorize any doctor or counselor; health practitioner; hospital, clinic or medical facility; insurer or reinsurer, consumer reporting agency; Medical Information Bureau, Inc.; or employer, to give the Company or its legal representative information about me. This includes information about my physical or mental health (including history, condition, diagnosis and treatment) except for drug and/or alcohol treatment records; other insurance coverage or employment status. The Company will use the information to decide if and to what extent I am eligible for insurance coverage or benefits under the Policy. This information will be treated as confidential.

Information regarding your insurability will be treated as confidential. We will not procure or cause to be prepared any investigative consumer report on your insurability. We or our reinsurers may, however, make a brief report to the Medical Information Bureau based strictly on information on the application and/or the enrollment form. The Bureau is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members for the purpose of protecting its members and their policyholders from bearing the expense of created by those who would conceal facts relevant to their insurability. If you apply to another Bureau member for life or health insurance or if a claim is made to such a company, the Bureau, upon request will furnish that company with information about you from its files. We or our reinsurers may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Upon request, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of any information in the bureau's files, you may seek correction from the Bureau. The address of the Bureau's information office is: [50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734 telephone number 781-751-6000.]

I understand that upon written request I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization. This authorization expires 24 months from the effective date of my coverage. I understand that a photocopy of this form is as valid as the original and that I have a right to receive a copy of this form upon request. **]**

[PRE-EXISTING CONDITIONS LIMITATION
(For Disability Income Coverage only)

I further understand that any condition that is excluded or limited by the policy will not be covered under this policy at any time. I understand that such excluded conditions are: any injury or sickness, diagnosed or undiagnosed, for which medical advice was given or treatment was recommended by or received from a physician, within six months before the effective date of my coverage.**]**

December 17, 2010

AMALGAMATED LIFE INSURANCE COMPANY
STATEMENT OF VARIABLE LANGUAGE
FORM ALSTDP-05
FORM ALSTDC-05

The purpose of statement of variable language is to achieve some flexibility in the use of the captioned form to accommodate the varying benefit needs or characteristics of the policyholder/ certificate holder by use of alternative language identified in brackets ([ ]) in the policy or certificate form. In selecting an alternative, attention would be paid to ensure that it is in compliance with all regulatory requirements of the state in which the policy is issued. When the variable is a numerical range within bracket, any number selected would be chosen from within the specified range. Similarly, when several alternatives are specified within bracket, any alternative selected would be one of the alternatives specified within bracket unless indicated otherwise.

Recurring Variables in Forms ALSTDP-05 (Policy) and ALSTDC-05 (Certificate):
1. Whenever the term "Employee" appears, it may be modified by the Policyholder.
2. Whenever the term "Employer" appears, it may be either "Policyholder" or a "Participant Employer",
3. Whenever the term "Plan/Schedule" appears, it may be either "Plan," or "Schedule".
4. The Home Office Address has been bracketed to allow for future changes in address, if any.

Form &Title: ALSTDP-05 – Group Short Term Disability Income Insurance Policy

Page/Paragraph	Section	Provision with Variable Language	Description of Variables
Pg. 1	**Face Page**		"John Doe" information will vary by Policyholder.
Pg. 4	**Premiums**	Initial Monthly Premium Rates	The initial monthly premium may be a flat rate or may be based on the amount of insured payroll. If initial monthly premium rate is based on the amount of insured payroll, the paragraph "For Short Term Disability Benefits . . . " will be included.
Pg. 4/5		Change in Monthly Premium Rates Paragraph 1 Paragraph 2 Paragraph 3	 Initial Monthly Premium rates are guaranteed for a range of 12 to 36 months. Renewal rates after the initial guarantee period may be changed after notice to the Policyholder. The range of days required for notice is 31 to 45days. The percentage change in number of insured employees that triggers the Company's right to change the premium rates during the Rate Guarantee period ranges from 10% to 20%.
Pg. 5		Experience Rating Refund	If the policy does not qualify for an Experience Rating Refund, this entire provision will be deleted. The time period for a credit due ranges from 1 to 3 years.
Pg. 7	**Policy Provisions**	Termination of Policy	Written notice of termination ranges from 31 to 60 days. Paragraph 1, 4th Bullet - The minimum percentage of persons eligible for coverage on a contributory basis ranges from 25% to 75%. Paragraph 2 - May be included or excluded dependent on Group Policy.

Form &Title: ALSTDC-05 – Individual Certificate – Group Short Term Disability Income Insurance

Page/Paragraph	Section	Provision with Variable Language	Description of Variables
Pg. 1	**Face Page**		"John Doe" information will vary by Policyholder.
Pg. 3	**Schedule of Insurance**		The entry regarding the plan's cost will vary based on whether the plan is contributory or not.
Pg. 3		Eligible Classes	Class descriptions are specific to each Policyholder. The description will vary to reflect job titles, job descriptions, work hours, employment status, union status, member status, geographic location or age.
Pg. 3		Full-time employment	The number of hours required to be considered a full-time employee will vary by Policyholder and range between 20 - 40 hours. There is no maximum.
Pg. 3		Eligibility Waiting Period	The waiting period will vary by Policyholder. The minimum is "none" and the maximum is 365 days/12 months.
Pg. 3		Annual Enrollment Period	This entry will only appear if the plan has an annual enrollment period.
Pg. 3		Weekly Benefit	The definition of Weekly Benefit will vary by Policyholder. It may be: (1) the lesser/greater of a percentage of weekly earnings or a flat benefit; (2) a percentage of weekly earnings; or (3) a flat benefit amount. If the Weekly Benefit is just a percentage, the amount of weekly earnings ranges from 30% to 75% . If the Weekly Benefit is just a flat benefit amount, the minimum weekly amount is $25 or $50 depending on policyholder option. There is no maximum. The Weekly Benefit may be reduced by Other Income Benefits. If it is not reduced, this sentence will be deleted.
Pg. 3		Minimum Weekly Benefit	A minimum weekly benefit may or may not be provided by a policyholder. This definition will be deleted if it is not applicable. If the policyholder does provide a minimum weekly benefit, it may be: (1) the lesser/greater of a percentage of the weekly benefit or a flat benefit; (2) only a percentage of the weekly benefit; or (3) a flat benefit amount. The minimum weekly benefit, flat $ amount ranges from $12-50 - $50 depending on the group plan. The minimum weekly benefit, percentage of the weekly benefit, ranges from 5% to 15%.
Pg. 3		Maximum Duration of Benefits	No PEX Limitation - 8 – 104 weeks PEX Limitation - 0 to 6 weeks.
Pg. 3		Benefits Commence	For disability caused by an accident, range is from the 1st to the 60th day of total disability.

			For disability caused by sickness, the range is from 4th – 30th day of total disability. If the "hospital confinement" is not included in the Policyholder's plan, the earlier commencement date statement will be deleted.
Pg. 3		Premium Rates	This section will only appear if the plan is contributory. Initial Monthly Premium rates are guaranteed for a range of 12 to 36 months Renewal rates may be experience rating depending on the size and/or demographics of the group. If the group is not experience rated, the last portion of this sentence will be deleted.
Pg. 5	**Definitions**		Any of the bracketed definitions may be deleted if they are not relevant to the Policyholder.
Pg.5		Current Weekly Earnings	May be modified to include Partial and/or Residual, if applicable.
Pg.5		Disability	May be modified to include Partial and/or Residual, if applicable.
Pg. 5		Disabled	May be modified to include Partial and/or Residual, if applicable..
Pg. 5		Other Income Benefits	Note: *The following definition of Other Income Benefits shows what we intend to use as a determination of other income benefits for most Policyholders. However, we reserve the right to amend, alter or revise these definitions to reflect the nature of the Policyholder and/or accommodate his or her request*.
Pg. 5		Other Income Benefits/Paragraph 1	- References to [or your family] may be deleted. - References to [spouse/children] may be deleted. - Items 1- 8 may be deleted or modified
Pg. 6		Other Income Benefits/Paragraph 2	
Pg. 6		Other Income Benefits/Paragraph 4	The pro-rata period ranges from 260 to 520 weeks.
Pg. 6		Partial Disability or Partially Disabled	The entire clause may be deleted if not applicable. 2a. Depending on the case definition of Partial Disability, the words [or any] may be deleted. 2b. The minimum percentage ranges from 20% to 40% and the maximum ranges from 60% to 80%.
Pg.6		Participant Employer	Definition will only be included if applicable to the Policyholder.
Pg. 6		Residual Disability or Residually Disabled	The entire clause may be deleted if not applicable. 2a. Depending on the case definition of Partial Disability, the words [or any] may be deleted. 2b. The minimum percentage ranges from 20% to 40% and the maximum ranges from 60% to 80%.
Pg. 7		Total Disability or Totally Disabled	The limit on pre-disability earnings may be deleted if not applicable to the Group Policy. The percentage of earnings ranges from 20% to 40%.
Pg. 7		Weekly Earnings	*There are 3 definitions of Weekly Earnings. Only one of*

			the definitions1, 2 or 3 will be included, based on the Group Policyholder's plan.
Pg. 7		Weekly Earnings/Definition 2	References to bonuses will be deleted if not included. The Period used to determine the average ranges from 12 to 36 months.
Pg. 8		Weekly Earnings/Definition 3	References to bonuses will be deleted if not included.
Pg. 8	**Eligibility and Enrollment**	Enrollment	*There are two provisions for "How to Enroll" one for plans that are non-contributory and one for plans that are contributory. Only one of these provisions will appear in the policy at issue. The caption (i.e. non contributory plans) is for clarification in this memo and will not appear in the policy.*
Pg. 9		How do you enroll? (non-contributory plans)	Will be deleted if contributory plan.
Pg. 9		How do you enroll? (contributory plans)	Will be deleted if non-contributory plan I If a Group plan has only one option, the phrase "or another option" will be deleted. Items 1 and 2 may be deleted if the Group plan does not include (annual enrollment) such a provision.
Pg. 9	**Change in Family Status**	What constitutes a Change in Family Status	Items 3 and/or 4 may be deleted if the Group plan does not include such provision.
Pg. 9, 10	**When Coverage Starts**	When does coverage start?	Paragraph 1 - will be deleted if the plan is contributory. Paragraph 2 - will be deleted if the plan is non-contributory. Paragraph 2, Item 3 - With annual enrollment plans, may be deleted; Enrollment date - may be on the first or last day of the month or any day in between based on the Group plan.
Pg. 9	**Changes in Coverage**		
Pg. 9		Can you change benefit options?	If the plan does not include an Annual Enrollment Period, item 1 will be deleted. Paragraph 2 - If the plan does not have more than one option, restrictions about greater than the next higher option will be deleted.
Pg. 10		When will a requested change in benefit options take effect?	Paragraph 1 - If the plan does not include an Annual Enrollment Period, paragraph (including items 1 and 2) will be deleted. If the plan includes an Annual Enrollment Period, enrollment date may be on the first or last day of the month or any day in between based on the Group plan. Paragraph 3 – Reference to PEX Limitations may be deleted dependent on the Group plan.
Pg. 11	**Disability Benefits**		
Pg. 11		How do benefits become payable for Total Disability?	Paragraph 2, last sentence - "The benefit will be further reduced. . .] is not applicable to plans that include partial or residual disability. Paragraph 3 – Reference to Minimum Weekly Benefit

			will be deleted if the Group plan does not include such benefit. Paragraph 4 - Reference to treatment by a family member may be deleted
Pg. 11	**Partial Disability Benefit**.		*This is an optional benefit. If elected by the Policyholder, we have two options available to calculate the benefit. Only one of the options will be included dependent on the election of the Group Policyholder.*
Pg. 12			
Pg. 12		Partial Disability Benefit (#2) How are benefits paid for Partial Disability?	Percentage % of work earnings will vary by Policyholder and range from 25% - 50%.
	Residual Disability Benefit		*This is an optional benefit. If elected by the Policyholder, we have two options available to calculate the benefit. Only one of the options will be included dependent on the election of the Group Policyholder*.
Pg. 12		Residual Disability Benefit (#2) How are benefits paid for Residual Disability?	Percentage % of work earnings may be between 50% – 100%. Paragraph 2 – Reference to a Minimum Weekly Benefit will be deleted if the Group plan does not include such benefit. Paragraph 3 – will be used if vocational rehabilitation included with Partial or Residual.
Pg. 13		How is the benefit calculated for a period of less than a week?	Calculation may be 1/7th, 1/6th or 1/5th of the weekly benefit.
Pg. 13	**Recurrent Disability**	What happens if you return to work as an Active Full-time employee and then become Disabled again?	The number of consecutive days ranges from 7 to 90 days.
Pg. 13	**Multiple Causes**	How long will benefits be paid if a period of Disability is extended by another cause?	Item 2 - Reference to PEX Limitations may be deleted.
Pg. 13	**Vocational Rehabilitation**	What is Vocational Rehabilitation?	Optional. May be deleted dependent on Group Plan .
Pg. 14	**Rehabilitative Employment**	Rehabilitative Employment	Optional. May be deleted dependent on Group Plan..
Pg. 14		Do earnings from Rehabilitative Employment affect the Monthly Benefit?	The reduction of income ranges from 25% to 70%.
Pg. 15	**Pre-Existing Conditions Limitation**		
Pg. 14		Are benefits limited for a Pre-existing Condition?	Item 1 - days range from 5 to 730 Item 2 - days range from 30 to 730
Pg. 14		What is a Pre-existing Condition?	Item 2 - days range from 90 to 365
Pg. 15		Is there continuity of	May be deleted depending on the Group Policyholder

		coverage from a Prior Plan?	plan.
Pg. 15		What is the Weekly Benefit for a Disability caused by such Pre-existing Condition?	May be deleted depending on the Group Policyholder plan
Pg. 16	**Exclusions**		
Pg. 16		What disabilities are not covered? Paragraph 1 Paragraph 2	Any one of or combination of Items 1 – 6 may be deleted May be deleted dependent on the Group Policyholders plan.
Pg. 16	**Termination**	When does your insurance terminate?	Item 5 may be deleted dependent on the Group Policy.
Pg. 17		May coverage be continued during a family or medical leave?	The provision may be deleted dependent on the Group Policy. Item 4e may be deleted if not applicable to the Group Policyholder.
Pg. 17		May coverage be continued during a lay-off?	The provision may be deleted dependent on the Group Policy. The duration for which the employer may continue the insurance ranges from 30 days to 365 days. Time may be expressed as days, weeks, months or years. Item 3e may be deleted if not applicable to the Group Policyholder.
Pg. 17		May coverage be continued during a leave of absence?	The provision may be deleted dependent on the Group Policy. The duration for which the employer may continue the insurance ranges from 30 days to 365 days. Time may be expressed as days, weeks, months or years. Item 4e may be deleted if not applicable to the Group Policyholder
Pg. 18		Must premiums be paid during disability?	May be deleted dependent on the Group Policyholder.
Pg. 18		Do benefits continue if the Group Insurance Policy terminates?/Paragraph 2	If the Policyholder is not a Participant Employer, [or the Employer's participation in such policy] will be deleted.
Pg. 21	**General Provisions**	Must one apply for Social Security Disability Benefits?	Provision is deleted if the maximum duration of benefits does not exceed 26 weeks.

AMALGAMATED LIFE INSURANCE COMPANY
333 Westchester Avenue, White Plains, NY 10604

GROUP INSURANCE APPLICATION

Application is hereby made to Amalgamated Life Insurance Company ("Amalgamated") on the basis of the data contained in this application, the group risk factors, the enrollment data and available experience data. The application in its entirety, and any required additional data, is subject to Amalgamated's approval before insurance can become effective.

If this application is approved by Amalgamated, it will be attached to and made part of the Group Polic(y)(ies). Insurance will become effective on the requested effective date shown below unless Amalgamated sends written notice of a different effective date.

If this application is not approved by Amalgamated, no insurance is in effect at any time and any deposit premium Amalgamated has received will be returned.

This application is made with the following deposit premium. The premium amount is estimated, as the amount due for the [first month]; and will be applied toward the first premium on the proposed Group Policy(ies); $ _____.

If any insurance requires employee contributions, any underwriting requirements for enrollment must be met before insurance can become effective. Requested effective date; _____.

Coverage(s) being applied for:

___ Life
___ AD&D Rider
___ Other Rider _____
___ Short Term Disability
___ Long Term Disability

W-2 Services Option (for Short Term Disability and Long Term Disability coverage only):

___ Option 1: Withhold state and federal income taxes and the employee's portion of FICA.
Prepare and file W-2 Forms.
___ Option 2: Withhold federal income taxes and the employee's portion of FICA.
Applicant waives W-2 Forms services.

A detailed description of the W-2 services elected by applicant pursuant to this application will be sent to the applicant via mail. Such services will be performed in accordance with the above election and established standard procedures.

Are there any companies that are subsidiaries or affiliates of the applicant, which are also to be insured?
____ Yes ____ No If yes, please furnish a listing, giving the name, address, effective date of coverage, and number of employees for each such company.

Is the benefit plan, for which insurance is being requested, subject to the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended? ____ Yes ____ No
If yes, identify the Plan Number: _____

Sales Representative for Amalgamated: _____

Regional Office: _____ Name of Agent/Broker: _____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

***For Applicant**:*

_____
Legal Name of Entity

_____ _____
Signature Date

_____ _____
Name and Title of Authorized Signature. Employer Tax Id No.

AMALGAMATED LIFE INSURANCE COMPANY
333 Westchester Avenue White Plains, New York 10604
LIFE INSURANCE AND DISABILITY ENROLLMENT FORM

☐ Initial ☐ Change ☐ Termination ☐ Reinstatement

TO BE COMPLETED BY THE EMPLOYEE

Name Last	**First**	**M.I.**	**Birth Date: MM/DD/YY**

Social Security No.	**Sex** ☐ **M** ☐ **F**	**Marital Status** ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced	**Date of Marriage**: **MM/DD/YY**

Employee Home Address Street	**City**	**State**	**Zip**

Dependent Information (complete only if coverage is available & elected) (Dependent Life only)

	Last	**First**	**M. I.**	**Sex: M/F**	**Birth Date: MM/DD/YY**
Spouse					
Child					
Child					
Child					

Indicate type of coverage below. You may only elect coverages reflected in your Employer's contract. (*You will not be covered for coverages not included in your Employer's contract*.) To elect coverage check the box marked "Y". To decline coverage check the box marked "N"

Basic Life ☐Y ☐N Amt $_____	**Supp Life** ☐ Y ☐ N Amt $_____ Basic Income $_____ Other	**AD/D** Rider ☐ Y ☐ N **Other Rider** (please specify) _____ _____	**[Weekly] Disability** ☐Y ☐N Flat Amt $_____	**LTD** ☐ Y ☐ N Amt $_____

Dependent Life Spouse ☐ Y ☐ N Amt $_____ Child ☐ Y ☐ N Amt $_____	**Supplemental Life** ☐ **Y** ☐ N	**LTD Buy-Up** Option 1 _____% Option 2 _____%

Beneficiary Designation - Please refer to the reverse side for important information regarding beneficiary designation.

Full Name Address SSN Relationship DOB

Primary _____

Contingent _____

☐ I hereby apply for the coverages I have indicated above on behalf of myself and all dependents listed. I authorize my employer to make the appropriate deductions, if any, from my wages to pay for my share of the cost. I understand that the coverages available to me are in accordance with the provisions of the contract between Amalgamated Life and my Group Plan.

☐ I hereby waive coverages offered to me. I understand that if I desire to apply for any of these coverages at a later date, I will be required to furnish, at my own expense, medical evidence in support of insurability that is satisfactory to Amalgamated Life, before my coverage will become effective.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature _____ **Date** _____

TO BE COMPLETED BY THE EMPLOYER

Policy Symbol	Policy Number	Bill Unit	Loss Unit	Original Effective Date of Policy
Employer Name	Employee Hire Date	Effective Date of Coverage		
Employee Occupation	Employee Class	Life [Weekly] Disability LTD		
Salary $_____ ☐Annual ☐Monthly ☐Weekly ☐Hourly				
Termination Date		Reinstatement Date		

NAMING YOUR BENEFICIARY

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number, relationship and, if a minor, the age of that minor. If the beneficiary is not related either by blood or marriage insert the words, **"Not related."** If you need assistance, contact your company representative or your own legal counsel.

Following are examples of the most common designations:

Mary J. Doe, Wife (not Mrs. John Doe).

Mary J. Doe, Wife, if living, otherwise to Joseph W. Doe, Son.

Mary J. Doe, Wife, if living, otherwise to Jane Doe, Daughter, and Joseph W. Doe, Son, in equal shares or to the survivor.

Estate of the Insured

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example "1/3 to Mary Jones, Mother and 2/3 to Edith Jones, Wife."

If you find that more space is needed for naming your beneficiary(ies) than provided on this form please attach a separate sheet(s). Sign and date each sheet.

AMALGAMATED LIFE INSURANCE COMPANY
333 Westchester Avenue White Plains, NY 10604

EVIDENCE OF INSURABILITY FORM

[Applicants] must complete this form if they have requested insurance coverage for themselves [or any of their family members] and are required to show evidence of good health. For questions about how to complete this form, call Amalgamated Life Insurance Company (the "Company") at **[1-800-331-7234]**

Upon Completion: Send [both the [Policyholder] and [Applicant] sections of] this form to:
Amalgamated Life Insurance Company
Group Life & Health Insurance Underwriting
[P.O. Box 2999, Amalgamated, CT 06014-2999]

Please remember your form can not be processed without your signature and current date.
Please keep a copy of the completed forms for your records.

Check Applicable Coverage	☐ **Life Insurance**	☐ **Short Term Disability**	☐ **Long Term Disability**

[INSTRUCTIONS

[[Policyholder's] Responsibility

1. Fill out the [Policyholder] Section completely. Please note an incomplete form will result in a delay in processing your request for insurance. Refer to your Policy and employee records. [These records are your property and are not on file with the Company's Group Medical Underwriting Unit.]
2. In Section #1 of this [application] form ("Who Requires an [Application]?") indicate with a check mark all who are required to provide evidence of good health – [employee, spouse or child- and for each,] and check the reason(s) why. Refer to your Policy and employee records for all requirements, limitations and exceptions. Employees or spouses signing up after their new hire eligibility period will be responsible for any underwriting costs.
3. In Section (#2 "Coverage Summary,") complete all coverage amounts for each [Applicant]. **[Basic Life Coverage is important and required for all [Applicants] requesting additional Life coverage.]** refer to your employee records to find current coverage amounts. Please note that the Company does not have access to employee records for coverage amounts.
4. Complete the [Policyholder] section and forward the entire form to the employee who needs evidence of insurability.
5. No premiums should be deducted for additional amounts until a final decision regarding coverage is received from the Company's Underwriting Unit.**]**

[[Applicant's] Responsibility

1. [Make sure your Employer has already completed the [Policyholder] Section of this form in full.]
2. [The [Policyholder] Section clarifies which [Applicants] need to show evidence of good health and should be listed on this [application] form. Refer to ("Who Requires an [Application]?") in the **[Policyholder] Section** of the form where a box has been marked for each person who is required to fill out this [Application] form - [you (the employee), your spouse or child.] Enter the names of these individuals on the [Application] under "[Applicants] Requiring Health Evaluation," and fill in the information requested.]
3. Answer all questions completely and accurately. Even minor details like height and weight are very important and must be accurate.
4. An [Applicant] who has not enrolled by the end of the new hire eligibility period (shown in the [Policyholder] Section #1) will be responsible to pay for the cost of physical exams, medical records or medical tests if they are required during the underwriting process.
5. YOU, THE [EMPLOYEE] MUST SIGN THIS FORM (even if you yourself are not applying for coverage). Use your full legal signature, and enter the date signed. [Your spouse must sign this form ONLY if using this form to apply for coverage. He or she must use a full legal signature and enter the date signed.]
6. **[BOTH THE [EMPLOYER] AND [EMPLOYEE] SECTIONS OF THIS FORM MUST BE COMPLETED AND RECEIVED BY THE COMPANY WITHIN [30 DAYS] OF THE SIGNATURE DATE.]**
7. The medical and personal information you complete on this form will be considered "current" for [90 days]. Leaving information blank can result in delays or may result in your file being closed.

]

[POLICYHOLDER INFORMATION

[Policyholder] Section Please print in blue or black ink. Initial any changes. Do Not Erase			
[Policyholder] Name:			
[Division/Subsidiary Name:]			
[Participating Organization:]			
[Policy No.]			
[Certificate No.]			
[Policy Effective Date]			
[Mailing Address: Street:	City:	State:	Zip Code:]
[Benefits Contact Person (If Applicable): Telephone Number:		E-Mail:]	
[[Applicant] Name/[Applicant] Social Security Number/Date of Hire/Family Status Change Date/[Applicant] Base Annual Earnings (BAE)$]			

]

PROPOSED INSURED INFORMATION

[Applicant]/Proposed Insured Information Section Please print in blue or black ink. Initial any changes. Do Not Erase	
Answer all the questions. DATE and SIGN this form in all areas indicated	Mail the completed [Policyholder] and [Applicant] section(s) to: Amalgamated Life Insurance Co. Group Life & Health Ins. Underwriting [P.O. Box 2999 Amalgamated, CT 06104-2999]

[Applicant's] Name (First, Middle Initial, Last)			
☐Male ☐Female			
Height:___ft. ___in			
Weight: _____lb.			
Social Sec. No.:			
Mailing Address: Street:	City:	State:	Zip Code
Phone Number (Daytime/Evening):			
Date of Birth:			
[Age Last Birthday:]			
Place of Birth: (Town, State, Country)			
[Occupation/Title:]			
[Position/Duties:]			
[Date of Hire]			
Effective Date			
[Business Address: Street:	City:	State:	Zip Code:]
[E-Mail:]			
[Can we call you for any additional or missing information? YES: ☐ NO ☐What is the best time to call you?]			
[Business Telephone:]			

[1.Who requires an [Application]
Check box for each [Applicant] who requires evidence of good health with an [Application], and specify the reason(s) why.
Check all reasons that apply. Identify all [Applicants] requiring an [Application].

[IEE Employee	☐**New Hire** Newly hired employee electing coverage for the first time during normal eligibility period.*	☐**Over Guaranteed Issue ("GI") Limit** Election being made that requires medical underwriting, as it is above the GI limit*	☐**Opting up to Higher Level of Coverage** e.g. from 1 to 2 times salary or increasing in specified incremental dollar amounts as allowed by the plan.*	☐**Late Entrant** Employee who enrolled outside one of the following eligibility periods, usually 31 days from date of hire or from date of family status change, or an open enrollment.*	☐**Change in Family Status** Employee change in coverage being made within 31 days of a qualified change in family status.* (marriage, divorce, birth of a child, etc)**]**
[SP Spouse	☐**New Hire** Spouse electing coverage for the first time with a newly eligible employee during normal eligibility period.	☐**Over Guaranteed Issue Limit** Election being made that requires medical underwriting, as it is above the GI limit.*	☐**Opting up to Higher Level of Coverage** e.g. from $10,000 to $20,000 in coverage.*	☐**Late Entrant** Spouse did not enroll during one of the following eligibility periods: usually 31 days from employee date of hire or from date of family status change*	☐**Change in Family Status** Newly eligible spouse qualifies for GI coverage if elected within 31 days of the change in family status.***]**
[CH Child	☐**New Hire** Child electing coverage for the first time with a newly eligible employee during normal eligibility period.	☐**Over Guaranteed Issue Limit** Election being made that requires medical underwriting, as it is above the GI limit.*	☐**Opting up to Higher Level of Coverage** e.g. from $10,000 to $20,000 in coverage.*	☐**Late Entrant** Child did not enroll during one of the following eligibility periods: usually 31 days from employee date of hire or from date of family status change.*	☐**Change in Family Status** Newly eligible child qualify for GI coverage if elected within 3 1 days of the change in family status.***]**

*Please Refer to your policy and employee records for coverage amounts, eligibility periods (for Late Entrant determination), Guaranteed Issue limits, exceptions for salary increases and rules for "opting up." Please check the policy guidelines for Change in Family Status rules and exceptions. **]**

[

[Applicants] Requiring Health Evaluation (This is critical information and if left blank there will be a delay in processing.) List below the names of [Applicants] identified in Section 1.								
First Name, M.I., Last Name	**[APPLICANTS]**	**HEIGHT (ft/in) Required**	**WEIGHT (lbs) Required**	**DATE OF BIRTH Required Month**	**Day**	**Year**	**GENDER**	
[	[Applicant]						M	F]
[	Spouse						M	F]
[	Child						M	F]

]

[

If Dependent Coverage is desired, complete the following:				
Full Name	Relationship	Birth Date	Height	Weight

]

[OTHER INSURANCE INFORMATION

Does anyone proposed for coverage have any [Life/Disability Income] Insurance in force or pending with this or any other company? ☐Yes ☐No If yes, give details:

Name	Company	Face Amount	Monthly Benefit	Benefit Period	Waiting Period	To be replaced? Yes	No

]

[Please check "Yes" or "No" By applying for this insurance, do you intend to replace, discontinue, or change an existing policy of life insurance? ☐Yes ☐No **]**

[COVERAGE REQUESTED

[COVERAGE REQUESTED: ☐ New Coverage ☐ Change in Coverage

Disability Income

[Weekly] Benefit Amount: _____ Payment Period Option: _____ Waiting Period Option: _____

Is the [Weekly] Benefit Amount herein applied for equal to or less than [60%] of your Basic [Weekly] Pay minus any Other Income Benefits? ☐ Yes ☐ No **]**

[Life Insurance Amount Desired ([$10,000] minimum up to [$100,000] maximum in [$10,000] increments) _____

_____
[Proposed Insured]

[_____
Spouse

Please indicate if request is for ☐New Coverage

☐Change in Coverage

The Spouse may not be covered under a Plan with benefits greater than the Member's Plan.]

[IF REQUEST IS TO CHANGE EXISTING COVERAGE, PRINT ONLY THE ADDITIONAL AMOUNT DESIRED]

]]

[2. Coverage Summary - For each [Applicant,] complete all three columns

[Life Coverages: Be sure to include any in force Basic Life coverage as a dollar amount for all [Applicants] requesting supplemental life coverage. Refer to employee records for Current Coverage Amounts. For most policies, Life coverage can be calculated as 1, 2, 3 etc. times salary or in dollar amount increments for increment plans.**]**

[[Applicants] for Life Coverage	**Current Coverage Amount** *(This includes any GI coverage if eligible. This would apply to new hires electing for the first lime. If late entrant this amount should be zero)*	**Additional Amount Applied For** *(This amount reflects only the amount to be medically underwritten)*	**Total Coverage** *(Combined total of the amount currently in force and the amount being underwritten)*
Employee: Basic Life Salary multiples for BAE plans	**Required if Basic Coverage offered** **$__,__ __ __, __ __ __** ☐**1x** ☐ **2x** ☐ **3x** ☐ **4x** ☐ **5x** **_____x Other multiple**	**$__,__ __ __, __ __ __** ☐**1x** ☐ **2x** ☐ **3x** ☐ **4x** ☐ **5x** **_____x Other multiple**	**$__,__ __ __, __ __ __** ☐**1x** ☐ **2x** ☐ **3x** ☐ **4x** ☐ **5x** **_____x Other multiple**
Employee: Supplemental Life or Voluntary Life Salary Multiples for BAE	**$__,__ __ __, __ __ __** ☐**1x** ☐ **2x** ☐ **3x** ☐ **4x** ☐ **5x** **_____x Other multiple**	**$__,__ __ __, __ __ __** ☐**1x** ☐ **2x** ☐ **3x** ☐ **4x** ☐ **5x** **_____x Other multiple**	**$__,__ __ __, __ __ __** ☐**1x** ☐ **2x** ☐ **3x** ☐ **4x** ☐ **5x** **_____x Other multiple]**

[Coverage Summary (continued from previous page)]			
[[Applicants] for Life Coverage	**Current Coverage Amount** *(This includes any GI coverage if eligible. This would apply to new hires electing for the first time. If late entrant this amount should be zero)*	**Additional Amount Applied For** *(This amount reflects only the amount to be medically underwritten)*	**Total Coverage** *(Combined total of the amount currently in force and the amount being underwritten)*
[Spouse: Basic Life	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __**
Supplemental Life or Voluntary Life	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __]**
[Child: Basic Life	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __**
Supplemental Life or Voluntary Life	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __**	**$__,__ __ __, __ __ __]]**
[Long Term Disability Coverage: Refer to employee records for the benefit percentage selected and calculate that percentage of their annual salary. Then calculate the monthly benefit amount by dividing by 12. **]** **[Short Term Disability Coverage:** Refer to employee records for the benefit percentage selected and calculate that percentage of their annual salary. Then calculate the weekly benefit by dividing by 52.**]**			
[[Applicants] (employees only)	**Current Benefit Amount**	**Additional Benefit Amount**	**Total Benefit Amount**
[Employee: Long Term Disability	**$___ ___, ___ ___ ___ per month**	**$___ ___, ___ ___ ___ per month**	**$___ ___, ___ ___ ___ per month]**
[Employee; Short Term Disability	**$___ ___, ___ ___ ___ per week**	**$___ ___, ___ ___ ___ per week**	**$___ ___, ___ ___ ___ per week]]**

]

[The following costs were calculated based on your age as of [January 1, 2009], your [annual salary of $50,000] and [12 (Monthly) deductions]. Your employer gave this information to the Company. Please contact your benefits administrator immediately if it is incorrect.

[Voluntary Long Term Disability Insurance

You have the opportunity to enroll in [the Company's Voluntary Long Term Disability (LTD) insurance plan]. LTD insurance helps to replace your income if you are sick or injured and cannot work and is designed to begin after you have been Disabled for a predetermined waiting period, known as the elimination period, of [180 days]. This plan provides you with income protection to replace up to [60%] of your regular pay, to a maximum monthly benefit of [$5,000].

☐ I **elect** to enroll in the Voluntary LTD plan at a [monthly] cost of [$ 1.00.*]
☐ I **decline** to enroll in the Voluntary LTD plan.

*Your cost may change if your salary changes within the benefits plan year.**]**

[The following costs were calculated based on your age as of [January 1, 2009] and [12 (Monthly) deductions.] Your employer gave this information to the Company. Please contact your benefits administrator immediately if it is incorrect.

[Voluntary Short Term Disability Insurance

You have the opportunity to enroll in [the Company's Short Term Disability (STD) insurance plan.] STD insurance helps to replace your income if you are sick or injured and cannot work. This coverage commences on the [1st] day of accident and the [8th] day of sickness and is designed to continue for a period of [13] weeks.] This plan provides you with income protection to replace up to [60%] of your earnings, to a maximum pay period benefit of [$1,000.]
☐ I **elect** to enroll in the Voluntary STD plan at a [weekly] cost of [$1.00.*]
☐ I **decline** to enroll in the Voluntary STD plan.
*Your cost may change if your salary changes during the plan year.**]**

[Supplemental Life Insurance – Employee

You have the opportunity to enroll in [the Company's Supplemental Life Insurance plan.] Your election may be made in increments of [$10,000], not to exceed [3] times your salary or [$350,000], whichever is less. If you elect an amount that exceeds the lesser of [3] times your salary or the guaranteed issue amount of [$100, 000,] you will need to provide evidence of good health that is satisfactory to the Company before the excess benefit can become effective. The guaranteed issue amount may increase as it is subject to the final level of participation in this plan. Monthly costs, based on your age, are shown below.*

[Employee Life Amounts*	Monthly Cost*	Employee Life Amounts*	Monthly Cost*
$10,000	$0.50	$60,000	$3.00
$30,000	$1.50	$80,000	$4.00
$50,000	$2.50	$100,000	$5.00**]**

To determine the cost for Supplemental Life coverage in excess of [$100,000], add the cost of insurance for [$100,000] to the amount over [$100,000] that you wish to elect. For example, to calculate the cost for [$150,000], add the monthly cost for [$100,000] of coverage to the monthly cost for [$50,000] of coverage.]

☐ I **elect** to enroll in the Supplemental Life Insurance plan for $_____ at a monthly cost of $_____.
Employee Life Amount*

☐ I **decline** to enroll in the Supplemental Life Insurance plan.

[***NOTE**: Benefit reductions begin at age [65.] If you are or over age [65], the monthly costs shown are calculated based on your reduced benefit amount, not the employee life amount shown. Please see your benefits administrator for further information.] **]**

[Supplemental Life Insurance – Spouse

If you elect the Supplemental Life Insurance plan for yourself, you may elect Supplemental Life Insurance coverage for your Spouse. Your election may be made in increments of [$5,000] to a maximum of [$50,000] but may not exceed 50% of your approved election. If you elect an amount that exceeds the guaranteed issue amount of [$25,000], your spouse will need to provide evidence of good health that is satisfactory to the Company before the excess benefit can become effective. Use the rate chart and calculation line below to determine your Monthly cost for this coverage. Supplemental Spouse rates and premiums are based on the [employee's age, not the Spouse's age.]

[Spouse Life Amounts*	Monthly Cost*	Spouse Life Amounts*	Monthly Cost*
$5,000	$0.25	$30,000	$1.50
$15,000	$0.75	$40,000	$2.00
$25,000	$1.25	$50,000	$2.50**]**

☐ I **elect** to enroll in the Supplemental Life Insurance plan for $ _____ at a monthly cost of $ _____.*
Spouse Life Amount

☐ I **decline** to enroll in the Supplemental Life Insurance plan for my Spouse.

*Your cost may change if your age category changes during the benefit plan year.

SPOUSE

First Name	Last Name	Gender	Date of Marriage	Date of Birth	Benefit Amount

]

[Supplemental Life Insurance - Child(ren)

If you elect the Supplemental Life Insurance plan for yourself, you may elect Supplemental Life coverage for your Dependent Child(ren) from [date of birth] to [19] years ([23] years if a full time student). You may elect in increments of [$500] to a maximum of [$25,000] but you may not exceed [50%] of your approved election. Use the calculation line to determine your monthly cost for this coverage.

[Child Life Insurance Amount	$2,000	$4,000	$6,000	$8,000	$10,000
Cost per Child	$0.10	$0.20	$0.30	$0.40	$0.50**]**

☐ I **elect** to enroll my dependent child(ren) in the Supplemental Life plan for $ _____ at the monthly cost below.

# of Children	X	Cost Per Child Above	=	$ Your Monthly Cost
_____		_____		_____

☐ I **decline** to enroll in the Supplemental Life Insurance plan for my dependent child(ren).

CHILD(REN):

First Name	**Last Name**	**Gender**	**Date of Birth**	**Benefit Amount**

]

[BENEFICIARY INFORMATION

Beneficiary Designation

It is important that your beneficiary designation be clear so there will be no question as to your intent. It is also important that you name a primary and [contingent] beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number, relationship to you, date of birth and distribution percentage. If the beneficiary is not related either by blood or by marriage, insert the words, "Not Related" next to their stated relationship. If you need assistance, contact your benefits administrator or your own legal counsel. Following are examples of the most common designations:

Primary:	[Contingent]:
● Mary J. Doe, Wife (not Mrs. John Doe).	● Joseph W. Doe, Son and Jane Doe, Daughter, in equal shares 50%). ● Estate of the Insured

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example "33% to Mary Jones, Mother, and 67% to Edith Jones, Wife."

	Full Name	Address	SSN	Relationship	D.O.B.	%
Primary						
[Contingent]						**]**

[The beneficiary for life insurance on the lives of your spouse and/or children will automatically be you, if surviving, otherwise the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon your written request.)

Beneficiary - Print full name & relationship to you
Name _____ Relationship _____

The Proposed Insured will be the beneficiary for any Dependent Coverage desired. **]**

HEALTH INFORMATION

Health Questions

For all "YES" answers check Yes. For all "NO" answers check No.

[PLEASE ANSWER THE FOLLOWING AND GIVE DETAILS OF ALL "YES" ANSWERS BELOW:]

[If you are under age 75 please answer **all** of the following questions. **If you are age 75 or over, please answer** [all question(s)/questions marked [A1, B2, C1, D2, E1 thru E5]]]

[A1. [Has anyone proposed for coverage] been actively engaged in the full-time duties of [his/her/your] occupation during the [90 day] period immediately before the date of this [application]? [You: ☐ Yes ☐ No] [Spouse: ☐ Yes ☐ No] **]**

[A2. At any time during the past [12 months], [has anyone proposed for coverage] smoked cigarettes, cigars, or used a pipe, chewing tobacco, nicotine chewing gum or snuff? [You: ☐Yes ☐ No] [Spouse: ☐ Yes ☐ No] **]**

[To the best of the [Applicant's] knowledge and belief during the past [10 years] has any of the [Applicants] at any time been treated or consulted a physician for or told they have a problem with any of the following:	**YES**	**NO**
B1. [Abnormal pulse		
B2. Alcoholism		
B3. Anemia or other blood conditions		
B4. Anxiety		
B5. Any disease or disorder of the brain or nervous system		
B6. Any disease or disorder of the digestive system		
B7. Any disease or disorder of the glands		
B8. Any disease or disorder of the heart, blood or circulatory system		
B9. Any disease or disorder of the lungs or respiratory system		
B10. Any disease or disorder of the skin, bones, or joints, including neck or back disorders		
B11. Arthritis		
B12. Asthma		
B13. Blood or circulatory or vascular conditions		
B14. Blood or sugar in urine		
B15. Bronchitis		
B16. Cancer		
B17. Chest pain		
B18. Colitis		
B19. Diabetes		
B20. Dizziness		
B22. Drug or alcohol or nicotine use on a regular basis - Indicate amount used daily		

(Continued from previous page)		
	YES	NO
B23 Eating disorder		
B24. Elevated cholesterol		
B25. Enlarged lymph nodes or glands		
B26 Epilepsy		
B27. Eyes, ears, nose or throat – chronic		
B28. Gallbladder		
B29. Genital or reproductive organ problems		
B30. Heart condition		
B31. Heart murmur		
B32. Hepatitis		
B33. High blood pressure		
B34. Immune system - except HIV		
B35. Impaired sight or hearing		
B36. Insulin dependent diabetes		
B37. Intestines		
B38. Kidney disease		
B39. Kidneys, bladder, or urinary tract – chronic		
B40. Leukemia		
B41. Liver		
B42. Mental or Nervous disorders, including depression		
B43. Paralysis		
B44. Pneumonia		
B45. Psychiatric		
B46. Rectum		
B47. Recurrent or chronic sleep disorders/apnea		
B48. Respiratory problems		
B49. Rheumatism		
B50. Severe headaches		
B51. Shortness of breath		
B52. Skin disorders, moles, melanoma, basal cell carcinoma		
B53. Spleen		
B54. Stomach		
B55. Stroke		
B56. Thyroid		
B57. Tuberculosis		
B58. Tumor		
B59. Ulcer		
B60. Upper or lower digestive system **]**		
[C1. To the best of the [Applicant's] knowledge and belief, [Has anyone proposed for coverage] ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder except for HIV?**]**		
[C2. To the best of the [Applicant's] knowledge and belief, during the past [5 years] [has anyone proposed for coverage] consulted any physician, surgeon, psychologist, psychiatrist or other practitioner for any reason not previously noted on this [application]; or been confined or treated in any hospital, sanatorium or similar institution? **]**		

[ADDITIONAL QUESTIONS:	YES	NO
To the best of the [Applicant's] knowledge and belief, during the past [10 years] [has anyone proposed for coverage]:		
[D1. Had surgery or been told to have surgery?]		
[D2. Been in a hospital or other institution for diagnosis or treatment?]		
[D3. Had any injuries from a car accident, or filed a Worker's Compensation claim?]		
[D4. Been declined for any life or disability insurance coverage?]		
[D5. Consulted or been examined by any healthcare provider for anything other than normal physical exams or acute illness such as cold, flu or sore throat?]		
[D6. Had any lab tests, x-ray, electrocardiogram or other diagnostic testing other than those requested as part of routine physical with normal findings?]]		

[E1. To the best of the [Applicant's] knowledge and belief, during the past [2 years] [has anyone proposed for coverage] been hospitalized for any condition?]		
[E2. To the best of the [Applicant's] knowledge and belief, [has anyone proposed for coverage] been confined in a hospital, nursing home, sanatorium or similar institution due to illness in the past [6 months?]]		
[E3. To the best of the [Applicant's] knowledge and belief, [is anyone proposed for coverage] **currently** pregnant? [If yes, Name: _____ When is the baby due? _____ Are there any medical complications? _____ What was your pre-pregnancy weight?]_____]		
[E4. [To the best of the [Applicant's] knowledge and belief, [is anyone proposed for coverage] taking medication for any condition or disease?]		
[E5. To the best of the [Applicant's] knowledge and belief, are there any symptoms, injury, birth defect, congenital defect, disease or other disorder not mentioned above? Please list all.]		

(All Inclusive Additional Information)

If you answered "Yes" to any of the above questions, please explain the details. An additional sheet of paper may be used, if necessary.

Question Number	Name	Disorder or Reason	Dates To/From	Give details for any "Yes" answer. Explain nature of illness, number of attacks, duration, severity, treatment, names & addresses of physicians, hospitals, & date of full recovery.

(Individual Additional Information — May Follow Each Question)

[Applicant] name(s):	Question Number	Medical condition:	Date treatment started: Date admitted: Date discharged:
Treatment/Medication:	Date of last treatment:		Current Status:
Physicians name and complete address:			
Please provide Primary Care Physician's name and complete mailing address:			
			]

[Simplified Medical Underwriting Questions

During the past [5 years] have you been treated, diagnosed or received medical advice for a heart attack, stroke, cancer, back, muscle, joint or mental nervous disorders or Acquired Immune Deficiency Syndrome (AIDS)?

[Applicant] ☐ Yes ☐ No [Spouse ☐ Yes ☐ No] [Child ☐ Yes ☐ No]

Please review your answer to this question to be sure that you have answered it fully and truthfully. Answering "No" to this question will qualify you for coverage. Answering "Yes" to this question disqualifies you from automatic acceptance for coverage at this time. However, if you feel you have recovered or are no longer requiring medical services, you may ask for reconsideration by completing [an Application.] Please contact [your Human Resources department for this form.] **]**

I have read this completed application and represent that to the best of my knowledge and belief all statements and answers herein are complete, true and correctly recorded. All statements made by, or by the authority of, the applicant for the issuance, reinstatement or renewal of any such policy or contract shall be deemed representations and not warranties.

I also understand that although any misrepresentation contained herein or relied upon by the company will not render the contract void, such misrepresentation may be used to contest the validity of the coverage in a court of law, within the contestable period if such misrepresentation materially affects acceptance of the risk. This information may be used by the Company for plan administration purposes to decide if the person(s) is/are eligible for coverage.

Subject to the deferred effective date provision I understand that coverage will not become effective until the Company grants its underwriting approval. I do not receive temporary or conditional insurance coverage just because I submit an [application] and pay the first premium.

I certify that I have received the Notice of Insurance Information Practices. I agree that this document and all its contents shall form a part of my enrollment request for group benefits.

[[Applicant] Confirmation

I have been given the opportunity to enroll in [ABC Company's LTD Group plan effective June 1, 2002]. I understand that if I decline now, but later decide to enroll, I will be required to provide evidence of good health that is satisfactory to the Company and understand my request for coverage may be denied.

I authorize my employer to make the appropriate payroll deductions from my wages [on a post-tax basis.] I am not now disabled and I am performing all the duties of my occupation on a full-time basis. [My spouse is either actively at work or, if not employed, able to carry on all the normal and customary activities of a person of like age and sex in good health.]

I am aware that if participation requirements are not met, this plan will not be implemented and the coverage elected will not be in force. **]**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Please print [Applicant] Full Name (First and Last):			**[Please print Spouse's Full Name (First and Last)]**	
[APPLICANT'S] SIGNATURE (**required**) or Legal representative to [Applicant]	DATE SIGNED Relationship:	[OR	SPOUSE'S SIGNATURE (required only if applying for coverage)	DATE SIGNED**]**

[AUTHORIZATION

I authorize any doctor or counselor; health practitioner; hospital, clinic or medical facility; insurer or reinsurer, consumer reporting agency; Medical Information Bureau, Inc.; or employer, to give the Company or its legal representative information about me. This includes information about my physical or mental health (including history, condition, diagnosis and treatment) except for drug and/or alcohol treatment records; other insurance coverage or employment status. The Company will use the information to decide if and to what extent I am eligible for insurance coverage or benefits under the Policy. This information will be treated as confidential.

Information regarding your insurability will be treated as confidential. We will not procure or cause to be prepared any investigative consumer report on your insurability. We or our reinsurers may, however, make a brief report to the Medical Information Bureau based strictly on information on the application and/or the enrollment form. The Bureau is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members for the purpose of protecting its members and their policyholders from bearing the expense of created by those who would conceal facts relevant to their insurability. If you apply to another Bureau member for life or health insurance or if a claim is made to such a company, the Bureau, upon request will furnish that company with information about you from its files. We or our reinsurers may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Upon request, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of any information in the bureau's files, you may seek correction from the Bureau. The address of the Bureau's information office is: [50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734 telephone number 781-751-6000.]

I understand that upon written request I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization. This authorization expires 24 months from the effective date of my coverage. I understand that a photocopy of this form is as valid as the original and that I have a right to receive a copy of this form upon request. **]**

[PRE-EXISTING CONDITIONS LIMITATION
(For Disability Income Coverage only)

I further understand that any condition that is excluded or limited by the policy will not be covered under this policy at any time. I understand that such excluded conditions are: any injury or sickness, diagnosed or undiagnosed, for which medical advice was given or treatment was recommended by or received from a physician, within six months before the effective date of my coverage.**]**